

MEDICARE FRAUD AND ABUSE BY DURABLE MEDICAL EQUIPMENT SUPPLIERS

HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT OF THE COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES ONE HUNDRED SECOND CONGRESS FIRST SESSION

WEST CHESTER, PENNSYLVANIA, JUNE 21, 1991

Serial 102-40

Printed for the use of the Committee on Ways and Means



U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1992

50-364

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-037340-9

COMMITTEE ON WAYS AND MEANS

DAN ROSTENKOWSKI, Illinois, *Chairman*

SAM M. GIBBONS, Florida	BILL ARCHER, Texas
J.J. PICKLE, Texas	GUY VANDER JAGT, Michigan
CHARLES B. RANGEL, New York	PHILIP M. CRANE, Illinois
FORTNEY PETE STARK, California	DICK SCHULZE, Pennsylvania
ANDY JACOBS, Jr., Indiana	BILL GRADISON, Ohio
HAROLD E. FORD, Tennessee	BILL THOMAS, California
ED JENKINS, Georgia	RAYMOND J. McGRATH, New York
THOMAS J. DOWNEY, New York	ROD CHANDLER, Washington
FRANK J. GUARINI, New Jersey	E. CLAY SHAW, Jr., Florida
MARTY RUSSO, Illinois	DON SUNDQUIST, Tennessee
DON J. PEASE, Ohio	NANCY L. JOHNSON, Connecticut
ROBERT T. MATSUI, California	JIM BUNNING, Kentucky
BERYL ANTHONY, Jr., Arkansas	FRED GRANDY, Iowa
BYRON L. DORGAN, North Dakota	
BARBARA B. KENNELLY, Connecticut	
BRIAN J. DONNELLY, Massachusetts	
WILLIAM J. COYNE, Pennsylvania	
MICHAEL A. ANDREWS, Texas	
SANDER M. LEVIN, Michigan	
JIM MOODY, Wisconsin	
BENJAMIN L. CARDIN, Maryland	
JIM McDERMOTT, Washington	

ROBERT J. LEONARD, *Chief Counsel and Staff Director*
PHILLIP D. MOSELEY, *Minority Chief of Staff*

SUBCOMMITTEE ON OVERSIGHT

J.J. PICKLE, Texas, *Chairman*

BERYL ANTHONY, Jr., Arkansas	DICK SCHULZE, Pennsylvania
HAROLD E. FORD, Tennessee	E. CLAY SHAW, Jr., Florida
CHARLES B. RANGEL, New York	DON SUNDQUIST, Tennessee
ANDY JACOBS, Jr., Indiana	JIM BUNNING, Kentucky
ED JENKINS, Georgia	
MARTY RUSSO, Illinois	

CONTENTS

Press release of Friday, June 14, 1991, announcing the hearing	Page 2
--	-----------

WITNESSES

U.S. Department of Health and Human Services:	
Pat Gilmore, Investigator, Inspector General's Office	43
Larry D. Morey, Deputy Inspector General for Investigations, Inspector General's Office, Jack Hartwig, Regional Inspector General for Investi- gations, and Pat Gilmore, Investigator	56
U.S. Department of Justice, Michael M. Baylson, U.S. Attorney, Eastern District of Pennsylvania, and James G. Sheehan, Chief, Civil Division.....	66
Bell, Jeffrey M., M.D., Chester, PA	22
Fidale, Joan, Chester, PA	22
Kantner, Sally, Norristown, PA	7
Levin, Herbert N., Philadelphia, PA	37
Pennsylvania Association of Medical Suppliers, Ron Billingsley	84
Pennsylvania Blue Shield, Judith A. Krafzig-Kearney, Donald X. Baxter, and Tony Rivel	91
Robertson, Roberta, Wayne, PA	21
Smith, Clinton, A., Norristown, PA	18

SUBMISSIONS FOR THE RECORD

American Orthotic and Prosthetic Association, statement	110
Health Industry Manufacturers Association, Alan H. Magazine, letter	115

MEDICARE FRAUD AND ABUSE BY DURABLE MEDICAL EQUIPMENT SUPPLIERS

FRIDAY, JUNE 21, 1991

**HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON OVERSIGHT,
*West Chester, PA.***

The subcommittee met, pursuant to notice, at 10:30 a.m., in Courtroom No. 1, Chester County Courthouse, High and Market Streets, West Chester, PA, Hon. J.J. Pickle presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, JUNE 14, 1991

PRESS RELEASE #11
SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1135 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-5522

THE HONORABLE J. J. PICKLE (D., TEXAS), CHAIRMAN,
SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A FIELD HEARING ON MEDICARE FRAUD AND ABUSE
BY DURABLE MEDICAL EQUIPMENT SUPPLIERS

The Honorable J. J. Pickle (D., Texas), Chairman of the Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee on Oversight will hold a field hearing on Medicare fraud and abuse. Specifically, the Subcommittee will examine the issue of abuse of the Medicare program by durable medical equipment (DME) suppliers, as well as the Medicare policies and procedures for processing DME claims.

The Subcommittee will review specific cases in which Medicare beneficiaries, contacted by telephone by a DME supplier, were informed that they were entitled, under Medicare, to medical equipment free of charge. They were subsequently provided with the equipment, which in many instances, they neither needed nor wanted. The equipment included items such as moist heating pads, decubitus care mattresses (for preventing bed sores), and TENS units (transcutaneous electrical nerve stimulators, devices for the relief of pain with electric current). After doctors signed certifications that the equipment was medically necessary, bills for the equipment were submitted for reimbursement by Medicare, and in many instances, Medicare paid for the equipment.

The hearing has been scheduled for Friday, June 21, 1991, beginning at 10:30 a.m., in Courtroom #1, Chester County Courthouse, High and Market Streets, West Chester, Pennsylvania. The Subcommittee will receive testimony from invited witnesses, including Medicare beneficiaries solicited by DME telemarketers, who were subsequently supplied with unwanted equipment. The Subcommittee will also receive testimony from the Office of Inspector General, Department of Health and Human Services, and the Office of the U.S. Attorney, Eastern District of Pennsylvania, regarding their investigations of abusive and fraudulent DME activities in the Philadelphia area. In addition, Pennsylvania Blue Shield, the Medicare carrier for Pennsylvania, will present testimony regarding its efforts to monitor Medicare claims for DME and to evaluate the medical necessity for such equipment.

In announcing the hearing, Chairman Pickle stated: "In the Philadelphia area, unscrupulous DME suppliers have been preying upon unwitting Medicare beneficiaries to defraud the Medicare system. While this problem may be especially acute in Pennsylvania, it appears to exist in other parts of the country as well. Convinced by DME telemarketers that they are entitled to receive free equipment, senior citizens have received equipment they did not want and often cannot even use. Although Medicare beneficiaries haven't had to reach into their own pockets to pay for the equipment, the Medicare program has picked up the tab. As a result, thousands--perhaps millions--of dollars have been drained from Medicare trust funds. This country simply cannot afford for Medicare funds to be spent on useless equipment. We need to assess the effectiveness of our current safeguards intended to prevent this waste."

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Persons submitting written comments for the printed record of the hearing should submit six (6) copies by the close of business, Wednesday, July 24, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, room 1102 Longworth House Office Building, Washington, D.C. 20515.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Chairman PICKLE. The Chair will ask that the committee please come to order. We will ask our guests to take a seat.

The Subcommittee on Oversight of the Committee on Ways and Means is pleased to be here today in Chester County to receive testimony from those who have been affected by the DME problems that have occurred here.

I am going to yield first to the ranking member of the subcommittee, one of the better Members of the Congress and a very able and distinguished Member of our body. He is a very active member of this subcommittee, and I am going to yield to him for an opening statement.

Mr. Dick Schulze, we are pleased to be here in the Fifth District in Pennsylvania.

Mr. SCHULZE. Thank you, Mr. Pickle of Texas, the chairman of the subcommittee. I appreciate you and Mr. Jenkins of Georgia taking time out of your busy schedules to come and look at a problem we have here in southeastern Pennsylvania.

Mr. Chairman, I am pleased to join you in opening our hearing on abusive practices in the Medicare Program for durable medical equipment. I am pleased that you and other members were able to come to West Chester today, but unfortunately, the reason we are here is not a happy one.

The honest senior citizens of eastern Pennsylvania are being victimized by aggressive medical equipment suppliers. Some medical suppliers have been forcing unwanted and ineffective equipment onto Medicare beneficiaries. While the equipment may be of little value, they still charge a very high price for it.

These medical schemes are not limited to Pennsylvania. They are also occurring in other parts of the country. Medicare abuse has occurred in Tennessee and Florida. Any region which has a large population of senior citizens is a potential target. Therefore, the Medicare waste occurring in Pennsylvania may be part of a much larger problem.

A few years ago we were outraged when we read newspaper stories about the Pentagon paying \$600 for a toilet seat and \$200 for a hammer. A similar rip-off of taxpayer dollars is occurring today in the Medicare reimbursement for durable medical equipment. The Medicare system is paying premium prices for inferior equipment. It does wonders for the financial health of the company, but absolutely nothing for the health of the Medicare beneficiary.

For example, some medical companies are delivering simple foam mattress sets to beneficiaries and saying they are especially made to prevent bed sores. They charge Medicare \$726 for a foam mattress which costs them \$50. This represents a 1,700 percent markup. The added disappointment is that this equipment often does not help the person. It quickly ends up collecting dust in the closet or attic.

In one recent case, a Kennett Square beneficiary received a TENS unit, a gel flotation chair cushion and a four-piece flotation mattress after a smooth telephone sales pitch from one medical company. Last month the company was paid \$419 for just the TENS unit alone. The TENS unit probably could be made with parts from a Radio Shack for less than \$50.

The beneficiary did not need the equipment, since she manages to mow the lawn every week and take care of her own garden. She has tried to return the equipment, but so far the company has not sent anyone to her home to pick it up.

Medicare is a valuable program which provides hospital and doctor benefits to retired persons. It is funded by the hard-earned dollars paid by taxpayers, and it must be used in a responsible manner.

The abusive medical companies falsely tell beneficiaries that the equipment is free, but the fast talking and smooth talking of salespeople are not enough to fool the beneficiaries in the long run. Many beneficiaries are realizing that just because they do not have to pay it does not mean that no one is paying. Medicare is paying.

More and more beneficiaries are reacting to the practice of medical companies trying to force unwanted equipment upon them. These beneficiaries realize that when Medicare wastes money it reduces the funds available for use on legitimate, worthwhile medical expenses.

Today our subcommittee will hear the first-hand experiences of several Medicare beneficiaries. In addition, we will hear from other health care providers and from the Federal authorities. Our witnesses should give us a better picture of the fraudulent Medicare practices. We want to do all we can to identify the waste of Medicare funds and stop it.

An important reason to hold this hearing outside of Washington is so that we can draw more attention to the problem in a region which has been targeted by aggressive medical suppliers. An ounce of prevention is worth a pound of cure, and our hearing hopefully will be a dose of preventative medicine. An informed public is the best defense against the semilegal fraud being committed by some medical suppliers.

Mr. Chairman, I join you in welcoming our witnesses and the subcommittee to Pennsylvania.

Chairman PICKLE. Thank you, Mr. Schulze. The Chair will now recognize Mr. Ed Jenkins from the State of Georgia, a member of the House Ways and Means Committee and one of our better Members of Congress.

Mr. Jenkins.

Mr. JENKINS. Thank you very much, Mr. Chairman. I, too, want to express my appreciation to you for holding these hearings and also for the leadership role that our colleague, Dick Schulze, has taken in this particular area.

I can think of no other area that is more important than to try to bring health care costs across this country into a reasonable rate that the average person can afford. This type of rip-off against the Medicare system is one of the reasons that medical health care costs continue to lead all other areas of Federal expenditures.

I want to commend some of the witnesses that have agreed to appear. If we had better cooperation from the recipients, the medical profession, as well as the legitimate sellers of durable equipment, working together to restrain the growth of health care costs we would all be better off.

I also want to express my appreciation to the U.S. attorney's office in the Eastern District of Pennsylvania for making this one

of their priority areas of prosecution and trying to restrain this type of activity.

Thank you, Mr. Chairman.

Chairman PICKLE. Thank you, Mr. Jenkins.

I am J.J. Pickle. I am from Austin, TX, and chairman of the subcommittee. Again I want to thank all the witnesses for coming out and for the interest expressed by the people.

This matter has been brought to our attention directly from Mr. Schulze that it should be looked into, and I know that many of you people locally have submitted information because you were concerned about what is happening.

Let me say simply before we start, this subcommittee is holding hearings on this and other matters affecting our jurisdiction where the effectiveness or the efficiency of a Federal program is being questioned.

This particular problem regarding DME sounds like it is one of the most scandalous practices that has been happening in this country.

Last year we went to Fort Lauderdale, FL, and held a hearing very similar, I believe, to this particular problem. If these kind of abuses are occurring in Florida and Pennsylvania they are occurring in other parts of the country.

The primary reason probably is money. Medicare is a very expensive program for the United States. This year we will spend approximately \$110 billion in Medicare expenses. It is the fourth largest or expensive program in the Government; defense, Social Security, interest on the national debt and Medicare.

It is estimated if we continue at the present level that Medicare will within the next 20 years outstrip the costs that we spend in defense or Social Security and in time will be more than all those total put together.

This is a very expensive program, and it is an invitation for fraud. Any time you spend \$110 billion that is almost an open invitation for con artists to come in and bilk the system.

Today we are going to hear from witnesses who have actually participated in this program. The people seated at the table before us are beneficiaries or who have had contact with this program.

[The statement follows:]

OPENING STATEMENT OF HON. J.J. PICKLE

During this Congress, the Committee on Ways and Means has undertaken to assure that the programs under its jurisdiction are effectively and efficiently serving the needs they were intended to meet. To that end, at today's hearing here in West Chester, the Subcommittee on Oversight is going to focus on a problem with the Medicare program. Medicare is one of the biggest programs in the Federal budget. This year, expenditures for Medicare will exceed \$100 billion. Any time you've got a program involving that kind of money, you're sure to attract people who would like to siphon a little of it off for their own benefit.

This area of the country has had a real problem with abuses by companies that market durable medical equipment (DME). DME consists of all kinds of medical equipment. It ranges from big-ticket items like customized wheelchairs to more mundane things like heating pads. Medicare pays for necessary items of DME. In fact, this year Medicare will pay somewhere between \$1.5 to \$3 billion for DME.

In Pennsylvania, DME suppliers have been using high-pressure sales techniques to induce Medicare beneficiaries to order items of DME. They usually tell the beneficiaries that they won't have to pay anything for the equipment. They get doctors to sign certificates of medical necessity, indicating that the equipment is necessary,

and then they bill Medicare. As a result, beneficiaries have gotten equipment they don't want or need, and Medicare has paid the bill. Money spent for this equipment was wasted.

This country has a serious budget problem. We can't afford to waste our Federal dollars. Fortunately, there are some folks here in Pennsylvania who don't want the Government to waste its money. They complained. And partially as a result of their complaints, some of these aggressive DME suppliers have been put out of business.

At today's hearing, we'll hear from some people who were fast-talked into ordering medical equipment. We'll also hear from the Inspector General for the Department of Health and Human Services and the U.S. Attorney for the Eastern District of Pennsylvania about what can be done to stop these aggressive DME suppliers. Field hearings like this one give us in Congress a picture of what is really going on around the country as a result of the laws we've passed, and I look forward to the testimony today.

Chairman PICKLE. I appreciate them coming and being a part to it. We have all the witnesses here except one, and we believe that she is on the way. We are going to proceed in the order from my right to left and let each person make their own statement.

I will first then recognize Sally Kantner, K-A-N-T-N-E-R, from Norristown, PA. I understand Ms. Kantner is accompanied by Clint Smith, also from Norristown. Ms. Kantner, would you proceed with your statement?

STATEMENT OF SALLY KANTNER, NORRISTOWN, PA

Ms. KANTNER. On Friday, June 11, 1990, a Bert Lorenz called me from Allstate Medical Equipment, located in Cheltenham, PA. She said I was insured to supply a chair, a gel cushion, a heating pad, a TENS unit and a mattress cover. All would be paid for by Medicare. They took my insurance information and doctor's name.

Then on Friday, July 13, there was a man at the door at noon-time, a Mr. Murray. He came with all the above equipment. He brought a mattress for a twin bed and put it on.

On Saturday, July 14, I called Allstate very upset. I had taken the mattress off of my double bed. The young man that I called at Allstate said it came in three pieces. I finally got it apart and put it in the other bedroom. It was very heavy to move.

On Tuesday, July 17, Allstate called at 9:15 a.m. The lady who called me before was very cool, not the same person as when she gave me her sales pitch. They came out by 11 a.m. and brought three more mattress parts to make a double bed mattress. I told Mr. Murray I did not want any of the equipment, but he would not listen. He just said you do not have to pay for anything. I tried to tell him it made my bed too high. There was no way I could put a fitted sheet with that and the regular mattress. He told me to get out of the way, and he and his helper went ahead and put it on the bed.

Then on Thursday, July 19, I went to the doctor and told him about this equipment. He said it would not help me and to call Medicare.

The whole thing with the delivery man upset me very, very much, so my daughter took over, which is Mr. Smith's wife. She called Allstate, and Murray called her back in the afternoon. They had quite a few words.

Then on July 20 my daughter called Allstate again and talked to Howard Friedman, the owner. He told her they would be out the

first week of August to take the equipment back. He was very nice at that time, but after that nothing happened, so then my son-in-law took over August 8.

[An attachment of Ms. Kantner follows:]

EXPLANATION OF BENEFITS



INDEPENDENCE
Blue Cross
Pennsylvania
Blue Shield

SARA KANTNER
714 HAMILTON ST
NORRISTOWN PA 19401

PENNSYLVANIA BLUE SHIELD
CUSTOMER SERVICE DEPARTMENT
POST OFFICE BOX 890034
CAMP HILL, PA 17089-0034
LOCAL: 717-975-7340

THE FOLLOWING CLAIM WAS PROCESSED IN
ACCORDANCE WITH YOUR COVERAGE THROUGH
BELL ATLANTIC
GROUP NUMBER: R7950001

PLEASE DIRECT ANY QUESTIONS YOU MAY HAVE
CONCERNING THIS EXPLANATION OF BENEFITS TO
THE ABOVE ADDRESS OR TELEPHONE NUMBER.
YOUR IDENTIFICATION NUMBER AND THIS CLAIM
NUMBER ARE REQUIRED FOR US TO HELP YOU.

SUBSCRIBER: SARA

KANTNER

PAGE 1

IDENTIFICATION NUMBER	CLAIM NUMBER	PATIENT NAME	DATE RECEIVED	DATE PROCESSED
175013473	1060724010	SARA	03/01/91	03/11/91

SUMMARY OF BENEFITS

TOTAL CHARGES.....	\$535.00	
LESS NON-ALLOWED AMOUNT.....	115.73	
LESS MEDICARE PAYMENT.....	335.42	
TOTAL PAID BY OCC.....		\$83.85

TOTAL PAYMENT THIS CLAIM (CHECK ENCLOSED).....		\$83.85
--	--	---------

THE TOTAL PATIENT RESPONSIBILITY IS.....	\$83.85
(THIS IS THE AMOUNT THE PROVIDER CAN COLLECT FROM YOU FOR THESE SERVICES.)	

PAID TO: SARA

KANTNER

CHECK NUMBER: 785076

DETAILED EXPLANATION OF SUMMARY

PROVIDER - ALLSTATE MEDICAL SERVICE DATES - 09/14/90-09/14/90
DURABLE MEDICAL EQUIPMENT PURCHASE

CHARGE.....	\$535.00	
LESS NON-ALLOWED AMOUNT - (SEE REMARK R003).....	115.73	
LESS MEDICARE PAYMENT.....	335.42	
PAYMENT FOR: MEDICARE PART B COINSURANCE.....		\$83.85

PAYMENT FOR THIS SERVICE.....		\$83.85
-------------------------------	--	---------

PATIENT RESPONSIBILITY.....	\$83.85
-----------------------------	---------

REMARKS

R003 THESE CHARGES ARE IN EXCESS OF THE AMOUNT ALLOWED BY MEDICARE. SINCE
THE PROVIDER ACCEPTED ASSIGNMENT AND MEDICARE PAID THE PROVIDER FOR
THESE SERVICES, BENEFITS ARE NOT AVAILABLE FOR THESE CHARGES AND THE
PROVIDER CANNOT COLLECT THIS NON-ALLOWED AMOUNT FROM THE PATIENT.

FOR YOUR INFORMATION: TO DATE, THIS PATIENT HAS SATISFIED \$62.00 OF
THE \$62.00 1990 BENEFIT PERIOD DEDUCTIBLE.

THIS IS NOT A BILL. It should be kept for your records.
Please see the reverse side of this explanation for additional information.

15. £19.94

9234

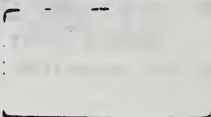
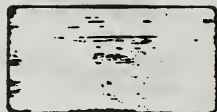
9-14-80
Dennard 3-01-76
Allister
Egip 535
Mori 335
Ck for 8385
H. en 8385
revised

Alstara



**Pennsylvania
Blue Shield**

Camp Hill, PA 17089



YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

EAST

HEALTH CARE FINANCING ADMINISTRATION

December 08, 1990
Need Help? Contact:

54002

SARA R KANTNER
714 HAMILTON ST
NORRISTOWN PA 19401-4202

Pennsylvania Blue Shield
1800 Center St.
P.O. Box 890065
Camp Hill, PA 17089-0065
Telephone 717-763-3601
Toll Free 1-800-382-1274

Assignment was taken on your claim for \$ 535.00 from
Allstate Medical Equipment I. (See item 4 on back.)

Medicare denied payment for all of these services.

Billed Approved

1 Supply/prosthesis (E0730)

Sep 14, 1990 \$ 535.00 \$ 0.00

Payment denied because the supplier did not obtain a written order from
your doctor prior to the delivery of this item.

Your claim was separated for processing and prompt
handling. You will receive another notice for the other
services.

If you have other insurance, it may help with the part Medicare did not
pay.

Do not accept durable medical equipment without discussing the need for
such equipment with your physician.

(You have met the deductible for 1990).

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this, you
must write to us before Jun 08, 1991 (See item 1. on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not
receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. 173013473A

Claim Control No. 3002639092410

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

EAST

HEALTH CARE FINANCING ADMINISTRATION

December 08, 1990
Need Help? Contact:

53999

SARA R KANTNER
714 HAMILTON ST
NORRISTOWN PA 19401-4202Pennsylvania Blue Shield
1800 Center St.
P.O. Box 890065
Camp Hill, PA 17089-0065
Telephone 717-763-3601
Toll Free 1-800-382-1274Assignment was taken on your claim for \$ 188.00 from
Allstate Medical Equipment I. (See item 4 on back.)

Medicare denied payment for all of these services.

Billed Approved

1 Durable Equipment (E0190) Sep 13, 1990 \$ 75.00 \$ 0.00
 Medicare cannot pay for this item. Although, it is helpful to you, your condition does not show a need for it.
 It appears that you did not know that Medicare would not pay for this service. So, Medicare does not hold you liable. We will pay any amount you have paid or pay your doctor or supplier for the service. To get this payment, bring or send to this office three things: (1) A copy of this notice. (2) Your doctor's or supplier's bill. (3) A receipt or other proof you have paid the bill. DO NOT apply for this payment if you knew Medicare would not pay. DO NOT apply if your doctor/supplier told you in writing, before furnishing the service, that Medicare would not pay.

1 Durable Equipment (E0189) Sep 13, 1990 \$ 19.00 \$ 0.00
 Medicare cannot pay for this item. Although, it is helpful to you, your condition does not show a need for it.
 It appears that you did not know that Medicare would not pay for this service. So, Medicare does not hold you liable. We will pay any amount you have paid or pay your doctor or supplier for the service. To get this payment, bring or send to this office three things: (1) A copy of this notice. (2) Your doctor's or supplier's bill. (3) A receipt or other proof you have paid the bill. DO NOT apply for this payment if you knew Medicare would not pay. DO NOT apply if your doctor/supplier told you in writing, before furnishing the service, that Medicare would not pay.

1 Durable Equipment (E0190) Sep 13, 1990 \$ 75.00 \$ 0.00
 Medicare cannot pay for this item. Although, it is helpful to you, your

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this, you must write to us before Jun 08, 1991 (See item 1. on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. 173013473A

Claim Control No. 3002639092400

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

EAST

HEALTH CARE FINANCING ADMINISTRATION

December 08, 1990
Need Help? Contact:

54000

SARA R KANTNER
714 HAMILTON ST
NORRISTOWN PA 19401-4202Pennsylvania Blue Shield
1800 Center St.
P.O. Box 890065
Camp Hill, PA 17089-0065
Telephone 717-763-3601
Toll Free 1-800-382-1274

condition does not show a need for it.

It appears that you did not know that Medicare would not pay for this service. So, Medicare does not hold you liable. We will pay any amount you have paid or pay your doctor or supplier for the service. To get this payment, bring or send to this office three things: (1) A copy of this notice. (2) Your doctor's or supplier's bill. (3) A receipt or other proof you have paid the bill. DO NOT apply for this payment if you knew Medicare would not pay. DO NOT apply if your doctor/supplier told you in writing, before furnishing the service, that Medicare would not pay.

1 Durable Equipment (E0189) Sep 13, 1990 \$ 19.00 \$ 0.00
 Medicare cannot pay for this item. Although, it is helpful to you, your condition does not show a need for it.
 It appears that you did not know that Medicare would not pay for this service. So, Medicare does not hold you liable. We will pay any amount you have paid or pay your doctor or supplier for the service. To get this payment, bring or send to this office three things: (1) A copy of this notice. (2) Your doctor's or supplier's bill. (3) A receipt or other proof you have paid the bill. DO NOT apply for this payment if you knew Medicare would not pay. DO NOT apply if your doctor/supplier told you in writing, before furnishing the service, that Medicare would not pay.

Your claim was separated for processing and prompt handling. You will receive another notice for the other services.

You are responsible to the physician/supplier for the difference of \$ 0.00 between the approved amount and the Medicare payment plus \$ 188.00 for uncovered services for a total of \$ 188.00.

If you have other insurance, it may help with the part Medicare did not pay.

Do not accept durable medical equipment without discussing the need for

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this, you must write to us before Jun 08, 1991 (See item 1. on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. 173013473A

Claim Control No. 3002639092400

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS — THIS IS NOT A BILL

EAST HEALTH CARE FINANCING ADMINISTRATION

December 08, 1990
Need Help? Contact:

54001

SARA R KANTNER
714 HAMILTON ST
NORRISTOWN PA 19401-4202Pennsylvania Blue Shield
1800 Center St.
P.O. Box 890065
Camp Hill, PA 17089-0065
Telephone 717-763-3601
Toll Free 1-800-382-1274

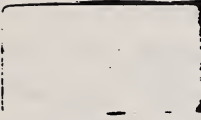
such equipment with your physician.

(You have met the deductible for 1990).

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this, you must write to us before Jun 08, 1991 (See item 1. on the back.)**DO YOU HAVE A QUESTION ABOUT THIS NOTICE?** If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. 173013473A

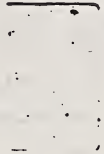
Claim Control No. 3002639092400



*My billed
Medicare
Sept 13, 1990*

*Medicare
denied payment
to Blue Shield*

*Pres 142515
533*



Pennsylvania
Blue Shield
Camp Hill, PA 17030

Medicare

Fri, June 22, 1990

Bert Lorentz cld from Allstate Med Equip Inc
Cheltenham 663 9200 (Insured) to supply chair,
Gel Cushion^{ed} heating pad, Tens Unit, mattress, cover,
for Arthritis patients, All paid by Medicare. Took
all ins. info and Dr's name.

Fri July 13, 1990

Man here at noon (Murray) with all above
Equip. Brought mattress for twin Bed. Put it on

Sat July 14, 1990

I called Allstate at 1155A - Very upset. Had taken
mattress off my double bed. Young man told me it
came in 3 pieces. I finally got it apart and put
it in other bed room. Very heavy to move.

Tues July 17, 1990

Allstate cld 915A Bert very cool, not the same
person as ^{when} she called the first time, with her "sales
girlz." They came out by 11A. Brought 3 more mattress
parts, to make a double bed mattress I told (Murray)

I didn't want any of the equipment, but he wouldn't
listen. Just said "you don't have to pay for
anything." I tried to tell him it made my bed
too high. No way, could I put a fitted sheet
on it and the regular mattress He told me to
get out and he and his helper went ahead and
put it on the bed.

Thurs July 19, 1990

I went to the Dr. Told him about this Equip. and he said it would not help me and to call Medicare. the whole thing with the delivery man upset me very, very much. So my daughter took over. She called Allstate and (Murray) called her back in the afternoon. They had give a few words.

Fri July 20, 1990

My daughter called Medicare. Was referred to Campbell. She told them not to pay for any of this Equipment. I was and ^{am} still too upset to call any one.

Mon July 23, 1990.

My daughter called Allstate Equipment and talked to Howard Friedman, (the owner) He told her they would be out the 1st week of August to take back the stuff. He was very nice that time. Nothing ever happend after that.

Chairman PICKLE. Mr. Smith, would you want to make any statement in connection with the statement that Ms. Kantner has made? You are accompanying her, so I would recognize you if you have anything to add to that.

Mr. SMITH. Yes, I would like to.

Chairman PICKLE. Would you identify yourself and your position?

STATEMENT OF CLINTON A. SMITH, NORRISTOWN, PA

Mr. SMITH. My name is Clinton Smith. I am Mrs. Kantner's son-in-law. I became involved after my wife had made several phone calls.

There was an arrangement to have the medical supplies picked up the following week, as Mrs. Kantner has stated in her testimony here. When indeed the arrangement was made, we waited a week. When they did not come in I called Allstate Medical Equipment and left several messages for Murray and for Mr. Friedman, the owner, and at no point was it returned. I tried for several days. I finally did get ahold of them. I believe it was around August 7, 8 or 9. I spoke to them on the phone.

Because of the difficulty that Mrs. Kantner had, at one point in time, and I do not know whether she reiterated this or not, but although they were very rude and discourteous when they came out to relocate the mattress, at one point in time she was in the hallway, and she does have a very, very narrow hallway, and they literally pushed her out of the way.

I think this is one of the things that she really wanted someone there to be there when they came to pick it up. My wife and I both suggested and made ourselves available to be there at that point in time, and they would have to make a prior arrangement to pick it up so that we could be there. We are within a half an hour of the house, and with just a phone call we could be there.

I did talk to them on the phone, and I suggested that. That did not seem agreeable to him. He did not feel it was necessary to have anybody else there other than Mrs. Kantner. I asked him when he was going to pick it up, and he at that point in time told me that if Mrs. Kantner wanted it picked up she would have to call.

I discussed some options with him. I said you know, there are other alternatives. If you do not want to come out and pick it up I can always arrange to have it taken and crated and shipped via another carrier collect to your location. I even volunteered to offer my services and return the goods. None of those suggestions were accepted.

At this point in time I did write a letter. The letter was addressed to Allstate Medical Supply to Mr. Friedman. In the letter I reiterated again exactly what my position was and how I felt about the necessity to get the product out of her house as she was not using it. I again stated that I would be more than willing to have it returned to him freight collect or I would return it myself. This was all in the letter that I wrote to him.

The letter was sent registered mail. It was never picked up. Unfortunately, because of the time that has elapsed, I cannot find it, but again, I am willing to testify that this is indeed the truth.

That was really the end of our communications. We just figured that sooner or later he is going to want his product. Now it has been over a year, and it is about time that there is some resolution. [The prepared statement follows:]

TESTIMONY OF CLINTON A. SMITH
NORRISTOWN, PA.

THE FOLLOWING CHRONICLE OF EVENTS DESCRIBES THE DIFFICULTY MRS. KANTNER, HER DAUGHTER, MRS. SALLY ANN SMITH, AND MYSELF HAVE HAD DEALING WITH ALLSTATE MEDICAL EQUIPMENT.

I BECAME INVOLVED WHEN MRS. KANTNER AND MY WIFE FAILED IN THEIR REPEATED ATTEMPTS TO HAVE THE MEDICAL EQUIPMENT REMOVED FROM MRS. KANTNER'S HOME. THE EQUIPMENT WAS UNKNOWNLY PRESCRIBED BY MRS. KANTNER'S DOCTOR. I CALLED MR. FRIEDMAN, THE OWNER OF ALLSTATE, ON OR ABOUT JULY 19, 1990, TO ASK THAT THE EQUIPMENT BE REMOVED FROM MRS. KANTNER'S HOME. MRS. KANTNER FELT IT DID NOT PROVIDE RELIEF OF HER ARTHRITIS PAIN, AS THE MEDICAL EQUIPMENT SUPPLIERS INDICATED THAT IT WOULD. MRS. KANTNER HAD MADE IT KNOWN TO MY WIFE AND MYSELF THAT WHEN THE EQUIPMENT WAS DELIVERED, THE DELIVERYMAN WAS DISCOURTEOUS. HE INSISTED THAT MY MOTHER-IN-LAW KEEP THE EQUIPMENT EVEN THOUGH SHE WAS HAVING SECOND THOUGHTS.

BECAUSE THE EQUIPMENT WAS INSTALLED IN THE WRONG ROOM, MRS. KANTNER REQUESTED IT BE REMOVED AND THE DELIVERYMAN RETURNED ONLY TO MOVE THE EQUIPMENT TO ANOTHER ROOM. MRS. KANTNER AGAIN ASKED TO HAVE THE EQUIPMENT REMOVED. HOWEVER, THE DELIVERYMAN INDICATED THAT HE WAS NOT AUTHORIZED TO REMOVE IT. WHEN I CONTACTED MR. FRIEDMAN ON JULY 19, 1990, AFTER NUMEROUS PHONE CALLS AND MESSAGES, I SUGGESTED THE EQUIPMENT BE REMOVED. MR. FRIEDMAN TOLD ME THAT THE AGREEMENT WAS BETWEEN MRS. KANTNER AND ALLSTATE AND SHE WOULD HAVE TO REQUEST REMOVAL. IT WAS AT THIS POINT I STATED THAT I WOULD REMOVE THE EQUIPMENT FROM MRS. KANTNER'S HOME AND SEND IT C.O.D. TO ALLSTATE. OF COURSE, THIS DID NOT SIT WELL WITH MR. FRIEDMAN AND THE PHONE CONVERSATION WAS TERMINATED BY BOTH PARTIES. AFTER THE PHONE CALL I DRAFTED A LETTER REITERATING MRS. KANTNER'S FEELINGS ON THE MATTER AND AGAIN SUGGESTED THE ALTERNATIVES. I SENT THE LETTER REGISTERED MAIL, HOWEVER, IT EVENTUALLY WAS RETURNED. UNFORTUNATELY, IN THE YEAR THAT HAS PASSED, I HAVE MISPLACED BOTH THE LETTER AND REGISTERED RECEIPT.

I HAVE STATED AS FACTUALLY AS POSSIBLE THE COMMUNICATION BETWEEN MRS. KANTNER, MYSELF AND ALLSTATE MEDICAL EQUIPMENT COMPANY.

Chairman PICKLE. Thank you very much, Mr. Smith.

The Chair would recognize next Roberta Robertson, who has just now arrived at the committee hearing. We are glad that you could make it, and we will go back to you and hear your statement. We are glad you are here.

Before I recognize you, let me also introduce another latecomer here, Congressman George Gekas, who represents the 17th District of Pennsylvania. I presume that is mid-Pennsylvania or thereabouts.

Mr. GEKAS. Central Pennsylvania.

Chairman PICKLE. He is a Member of the U.S. Congress and is here to participate with this subcommittee. Mr. Gekas, we are very glad to have you here. Would you want to make any particular statement at this point?

Mr. SCHULZE. Mr. Chairman, if I may, I would like to join in welcoming Mr. Gekas. He has long had an interest in this area. He is a member of the Judiciary Committee and as such has been involved with legislation which will strengthen the laws against fraud.

He particularly has an interest in the durable medical equipment and Medicare fraud area and has introduced legislation in this area.

We are pleased to have my colleague from Pennsylvania join us in the hearing today.

Mr. GEKAS. I thank the Chair and my colleague from Pennsylvania for the welcome. I am glad to see the gentleman from Georgia here as well.

All of us have in one way or another worked together on various functions in the Congress having to do with the Medicare issue. It is true that we are all interested in some of the aspects of the fraud that has been perpetrated.

I am so happy that the gentleman from Texas and the gentleman from Georgia have joined Congressman Schulze here in Pennsylvania, because, as has been pointed out, undoubtedly our population here in the Commonwealth is senior-oriented, and, therefore, Medicare fraud or any kind of Medicare problem impacts more than just significantly in our own area. I am glad to participate in the hearings and hope that there will be a beneficial result.

Thank you very much.

Chairman PICKLE. Thank you, Mr. Gekas. We are glad that you are with us.

Now the Chair is going to ask Roberta Robertson to make her statement.

Ms. Robertson.

STATEMENT OF ROBERTA ROBERTSON, WAYNE, PA

Ms. ROBERTSON. My notes may not be exactly accurate. The copies have been destroyed. WCAU channel 10, Herb Dennenberg, has the tapes and records.

As much as 2 years ago or more, someone called and stated they were updating my Medicare records. I foolishly assumed this to be a legitimate call from the Federal Government, and I answered a couple of simple questions.

Months later I received a huge carton from a supply house in Blackwood, NJ. I opted to not accept the package.

A couple of hours after the attempted delivery I received a call from a Miss Pearl on City Line Avenue in Philadelphia. She asked me if I had received a delivery. I told her I had not accepted it. I also asked her what the package contained.

At the time of the call I made notes as to the contents. Everything from a heating pad to knee and back braces and a wheelchair was on the way.

My doctor, Dr. Donald S. Miller, was interested when I mentioned my experience to him. As I told Dr. Miller, if I had needed all of this I would not be able to make my visits to his office. He commented that the contents represented thousands of dollars to Medicare and that my health did not warrant the use of these expensive items.

I did not need or want any of these items and was extremely upset to know of fraud to U.S. citizens and pursued this experience. From this point on, Herb Dennenberg of channel 10 somehow learned of this particular fraud being thrust upon the American citizens, and my role to this point is history.

Chairman PICKLE. We thank you for your statement.

The Chair is going to continue to receive testimony from those at the table, and then we will open it up to questions on each case or as the committee wishes to do it if that is agreeable to the committee.

We will proceed with the next statement. That will be from Jeffrey M. Bell, M.D. Dr. Bell is from Chester, PA, and Dr. Bell is accompanied by Joan Fidale, medical assistant.

Dr. Bell.

**STATEMENT OF JEFFREY M. BELL, M.D., CHESTER, PA,
ACCOMPANIED BY JOAN FIDALE, MEDICAL ASSISTANT**

Dr. BELL. Mr. Chairman, I am a physician in both Chester and Delaware Counties. I will just read the statement that I have presented to this committee.

I have been signing and filling out medical equipment forms that I assumed were coming from Medicare. I thought that all of these requests were being made by a visiting nurse or a patient's family.

It became clear to me after a patient brought one of these forms to my attention that the medical companies were soliciting elderly patients and telling them that they were eligible for such articles that I found totally unnecessary.

Since this has been brought to my attention I am certainly more careful of any and all forms received by my office from the medical companies. It is my concern that too many elderly patients have received equipment that Medicare has paid for, and this equipment is totally unnecessary.

Others and Mr. Schulze have talked about again the unnecessary nature and the inferior quality of these pieces of equipment. What has my concern and why I contacted Medicare was the concern about deceit.

In your packets, and I can just hold this up, these forms look like they are generated by Medicare. I would receive these, and if you

look at it there is a Blue Cross/Medicare logo on the top. This would come across my desk, and it looked like I was just cooperating with either one of the visiting nursing services for a patient or something that a family deemed necessary in terms of helping an older member of their family.

It was not until one of our patients called our office and spoke to Ms. Fidale and she brought it to my attention that there was no such generation and that in fact the company had sent her all this equipment, which again was not only unnecessary and unwarranted, but again, her feeling was, and I am sure that most patients assume, that this comes from their physician—that he or someone working with or for him has organized the use of whatever the equipment is.

[The attachments follow:]

Pennsylvania
Blue Shield



Memorandum

Camp Hill
Pennsylvania 17011-0062

To: L. Westra

From: D. Baxter

Subject: All State Medical Equipment Co.

Date: September 18, 1990

Linda attached you will find CMNs sent to me by Dr. Bell. The doctor did not believe his patients needed the equipment and he refused to sign the certificates. All State has become very aggressive in its solicitation. All State is also pushing TENs units and lymphedema pumps. Therefore you may want to open a survey on All State,

JEFFREY M. BELL, M.D.

STEPHEN D. CONRAD, M.D.

SUITE 403
CCMC PROFESSIONAL BUILDING I
15TH STREET AND UPLAND AVENUE
UPLAND, CHESTER, PENNSYLVANIA - 19013
(215) 872-8040

9/22/90

To Whom It May Concern:

Enclosed are the copies of the forms sent to my patient Sarah Garrett.

Mrs. Garrett was told by Allstate Medical Equipment that she needed and was entitled to any and all of the equipment typed in and or marked with an X. Not knowing why and what this was all about Mrs. Garrett brought these papers to my office because she felt that there must be a mistake. If you remember correctly this is the same company that has in the past sent letters and called by phone other patients of mine.

None of this equipment is necessary or will change the condition of Mrs. Garrett.

Sincerely,

Jeffrey M. Bell, M.D.

JMB/jf

Pennsylvania
BlueShield



Medicare

PPR-PA

Camp Hill PA 17011

ALLSTATE MEDICAL EQUIP., INC.
2 RYERS AVENUE
CRELTENHAM, PA 19012

Form Approved OMB No. 0938

Prescription For
☐ Initial
☐ Recertification
☐ Exchange of Equipment

Certificate of Medical Necessity

Medicare regulations require the following information be provided on claims for durable medical equipment. This form should be completed by the beneficiary's physician and returned to us with a completed Medicare claim form.

Patient's Name Sarah Garrett Health Insurance Claim No. 176 20 0348 A

Diagnosis _____

Date this equipment prescribed 8-7-90 Equipment will be needed for 36 months. Prognosis Stable

This prescription applies to rental period from Month 8 Day 7 Year 90 to Month _____ Day _____ Year _____

Please check the equipment you are prescribing and answer YES or NO to the corresponding question. Equipment with special attachments or features, or equipment not included below should be listed in the space provided.

- | | YES | NO | |
|--|-------------------------------------|--------------------------|---|
| ☐ Hospital Bed (Answer B) | ☐ | ☐ | A) Is the patient bed confined? |
| ☐ Hospital Bed—Variable Height (Answer B) | ☐ | ☐ | B) Does the patient's condition require positioning of the body or attachments which would not be feasible with the use of an ordinary bed? |
| ☐ Electric Hospital Bed (Answer C, D) | ☐ | ☐ | C) Does the patient's condition require frequent and/or immediate changes in position? |
| ☐ Side Rails (Answer E) | ☐ | ☐ | D) Can the patient operate the controls himself? |
| ☐ Commode—Standard (Answer A, F, M) | ☐ | ☐ | E) Is the patient disoriented at any time? |
| ☐ Commode—Adjustable (Answer A, F, M) | ☐ | ☐ | F) Is the patient room confined? |
| ☐ Trapeze Bar (Answer A, G, H) | ☐ | ☐ | G) Is there a need for the patient to sit up due to a respiratory condition, etc.? |
| ☐ Alternating Pressure Pad (Answer I, J) | ☐ | ☐ | H) Is there a medical need for a change in body position? |
| ☐ Wheelchair—Standard (Answer K) | ☐ | ☐ | I) Is the patient susceptible to decubitus ulcers? |
| ☐ Wheelchair with Elevating Legrests (Answer K) | ☒ | ☐ | J) Are you supervising the use of pressure pad? |
| ☐ Walker (Answer L, M) | ☐ | ☐ | K) Is the patient's condition such that the alternative would be bed or chair confinement? |
| ☐ Walker—Folding (Answer L, M) | ☐ | ☐ | L) Does the patient's condition impair ambulation? |
| ☐ Walker—Adjustable (Answer L, M) | ☐ | ☐ | M) Is the walker used for therapy? |
| ☐ Cane (Answer L, M) | ☐ | ☐ | N) Is the patient confined to floor without bathroom facilities? |
| ☐ Quad Cane (Answer L, M) | ☐ | ☐ | |

* ambulatory equipment such as a walker, cane or quad cane is being used with non-ambulatory equipment such as side rails, trapeze etc. please explain why both are medically necessary.

Items not included above and diagnosis or condition which warrants equipment.

8-7-90

E0190 Gel Mattress w/cover E0189

E0183 Gel Cushion

E0215 Moist heating pad To relieve pain of arthritis for long periods of time

1 equipment is not used in patient's home, please indicate the name and address of the facility where the patient resides. (Print or type)

IMPORTANT! This form must be signed and dated by prescribing before the equipment may be considered for payment (Print or type)

Physician's Name Dr. Jeffrey Bell

Physician's Phone No. 872-8040

Physician's Address CCMC Prof. Bldg.

Suite 403

Physician's Signature 15th & Upland st

Chester Pa 19013

Date _____

Dr.'s. Medicare I.D.# _____

ALLSTATE MEDICAL EQUIPMENT, INC.

2 Ryers Avenue • Cheltenham, PA 19012

(215) 663-9200

497-2711

PHYSICIAN'S PRESCRIPTION FORM

DATE: _____

Patient's Name

Joseph Barrett

Address _____

Phone Number _____

AMBULATORY AIDS

_____ Cane _____ Straight _____ Quad
 _____ Walker _____ Std. Folding _____ L.L. Wt.
 _____ Crutches _____ Adult _____ Pediatric

DECUBITUS CARE EQUIPMENT

☒ Decubitus Care Wheelchair Pad
☒ Decubitus Care Bed Mattress

BEDS & ACCESSORIES

_____ Egg Crate Mattress
 _____ Full Electric Hospital Bed
 _____ Hospital Bed Side Rails
 _____ Orthopedic Bed
 (Mattress and Box Springs)
 _____ Bed Board
 _____ Trapeze

PATIENT LIFTS

_____ Seat Lift Chair
 _____ Hoyer Lift
 _____ Lift Sling

PNEUMATIC APPLIANCE/LYMPHEDEMA PUMP

☒ Pneumatic Compressor

Appliances _____

Right leg

TRACTION

_____ Pelvic (Std. _____)
 _____ Cervical (Std. _____)

ORTHOPEDICS

_____ Soft Cervical Collar
 _____ Hard Cervical Collar
 _____ Lumbosacral Support
 _____ Molded Lumbosacral Support
 _____ Lumbosacral Corset (Hip size _____)
 _____ Spiral Knee Support
 _____ Hinged Knee Support
 _____ Neoprene Knee Sleeve
 _____ Elastic Ankle Support
 _____ Elastic Elbow Support
 _____ Elastic Wrist Support
 _____ Cook-up Wrist Splint

Other _____

BATH AND TOILET AIDS

_____ Tub Security Rails
 _____ Elevated Toilet Seats
 _____ Portable Home Whirlpool
 _____ Hand & Foot Whirlpool
 _____ Adjustable Std. Commode
 _____ 3-in-1 Commode

HEAT/COLD THERAPY

☒ Electric Moist Heat (Thermaphones)
 _____ Large _____ Medium _____ Cervical
 _____ Electric Dry Heat
 _____ Hydrocollator Units
 _____ Std. Set _____ Cervical Set
 _____ Colpates (size _____)

OXYGEN

_____ Oxygen Concentrator
 _____ Portable Oxygen System
 _____ Nebulizer
 _____ IPPB Machine

PILLOWS

_____ Std. Cervical Pillow
 _____ Cervical Pro Pillow
 _____ Bed Wedge
 _____ Sacroback-Back Support Cushion

ELECTROTHERAPY

_____ Portable TENS Units
 _____ Portable Muscle Stimulator

WHEELCHAIRS/GERIATRIC CHAIRS

_____ Reclining Chair
 _____ Standard Wheelchair
 (please note Specifications)
 _____ Std. Weight _____ Lightweight
 _____ Foot rests _____ Legrests
 _____ Fixed Arms _____ Removable Arms
 _____ Other _____

MISCELLANEOUS SUPPLIES

_____ Home Blood Pressure Monitors
 _____ Home Blood Glucose Monitors
 _____ Exercise Bikes
 _____ Exercise Rowers
 _____ Paraffin Wax Bath
 _____ Paraffinator

Physician's Name _____

Address _____

Phone _____

Signature _____

License Number _____

Diagnosis _____

ALLSTATE MEDICAL EQUIPMENT, INC.

2 Ryers Avenue • Cheltenham, PA 19012 • (215) 663-9200

Dear Dr. *Bell*

Enclosed are Medical Necessity Forms regarding your patient

Grace Moore. We have advised the patient
that we must have your consent for Medical Equipment.

When filling in the forms please make sure you include the following:

DIAGNOSIS & PROGNOSIS

A PRESCRIPTION FOR EACH ITEM

YOUR MEDICARE I.D.#

SIGNATURE & DATE

Medicare requires all of the above items to be on forms.

Thanking you in advance, we remain

Sincerely,

ALLSTATE MEDICAL EQUIPMENT, INC.

Pennsylvania
BlueShield



Medicare

Camp Hill, PA 17011

ALLSTATE MEDICAL EQUIP., INC.
2 HYDE AVENUE
CHELTENHAM, PA 19012

Form Approved OMB No. 0938-0

Prescription For:

- ☒ Initial
☐ Recertification
☐ Exchange of Equipment

Certificate of Medical Necessity

Medicare regulations require the following information be provided on claims for durable medical equipment. This form should be completed by the beneficiary's physician and returned to us with a completed Medicare claim form.

Patient's Name Grace Ross

Health Insurance Claim No. _____

Diagnosis _____

Date this equipment prescribed 2/19/90 Equipment will be needed for 36 months. Prognosis _____

This prescription applies to rental period from Month 2 Day 19 Year 90 to Month _____ Day _____ Year _____

Please check the equipment you are prescribing and answer YES or NO to the corresponding question. Equipment with special attachment or features, or equipment not included below should be listed in the space provided.

- | | | |
|--|--|--|
| ☐ Hospital Bed (Answer B) | ☐ YES ☐ NO | ☐ A) Is the patient bed confined? |
| ☐ Hospital Bed—Variable Height (Answer B) | ☐ | ☐ B) Does the patient's condition require positioning of the body or attachments which would not be feasible with the use of an ordinary bed? |
| ☐ Electric Hospital Bed (Answer C, D) | ☐ | ☐ C) Does the patient's condition require frequent and/or immediate changes in body position? |
| ☐ Side Rails (Answer E) | ☐ | ☐ D) Can the patient operate the controls himself? |
| ☐ Commode—Standard (Answer A, F, N) | ☐ | ☐ E) Is the patient disoriented at any time? |
| ☐ Commode—Adjustable (Answer A, F, N) | ☐ | ☐ F) Is the patient room confined? |
| ☐ Trapeze Bar (Answer A, G, H) | ☐ | ☐ G) Is there a need for the patient to sit up due to a respiratory condition, etc.? |
| ☐ Alternating Pressure Pad (Answer I, J) | ☐ | ☐ H) Is there a medical need for a change in body position? |
| ☐ Wheelchair—Standard (Answer K) | ☐ | ☐ I) Is the patient susceptible to decubitus ulcers? |
| ☐ Wheelchair with Elevating Legrests (Answer K) | ☒ | ☐ J) Are you supervising the use of pressure pad? |
| ☐ Walker (Answer L, M) | ☐ | ☐ K) Is the patient's condition such that the alternative would be bed or chair confinement? |
| ☐ Walker—Folding (Answer L, M) | ☐ | ☐ L) Does the patient's condition impair ambulation? |
| ☐ Walker—Adjustable (Answer L, M) | ☐ | ☐ M) Is the walker used for therapy? |
| ☐ Cane (Answer L, M) | ☐ | ☐ N) Is the patient confined to floor without bathroom facilities? |
| ☐ Quad Cane (Answer L, M) | ☐ | |

If ambulatory equipment such as a walker, cane or quad cane is being used with non-ambulatory equipment such as side rails, trapeze bar, etc., please explain why both are medically necessary.

Items not included above and diagnosis or condition which warrants equipment. 2/19/90

E0100 Adj Cane—THERAPEUTICALLY NECESSARY

E0179 Elevated Commode

If equipment is not used in patient's home, please indicate the name and address of the facility where the patient resides. (Print or type.)

IMPORTANT: This form must be signed and dated by prescribing physician before the equipment may be considered for payment. (Print or type)

Physician's Name Dr. Jeffrey Bell

Physician's Phone No. 872-8040 Chester, Pa 1901

Physician's Address Grover Chester Prof. Bldg.

Physician's Signature _____

Date _____

Dr's: Medicare I.D.#

UCSAS R 087

Pennsylvania
Blue Shield



1-5-84
R-14
Medicare

Camp Hill, PA 17011

ALLSTATE MEDICAL EQUIP., INC.
2 RYERS AVENUE
CHELTENHAM, PA 19012

Form Approved OMB No. 0938-01

Prescription For:
☒ Initial
☐ Recertification
☐ Exchange of Equipment

Certificate of Medical Necessity

Never Ordered

Medicare regulations require the following information be provided on claims for durable medical equipment. This form should be completed by the beneficiary's physician and returned to us with a completed Medicare claim form.

Patient's Name Marquette Lord Health Insurance Claim No. 195 05 1287 D

Diagnosis _____

Date this equipment prescribed 5-7-90 Equipment will be needed for 36 months. Prognosis stable

This prescription applies to rental period from Month 5 Day 7 Year 90 to Month _____ Day _____ Year _____

Please check the equipment you are prescribing and answer YES or NO to the corresponding question. Equipment with special attachments or features, or equipment not included below should be listed in the space provided.

- | | YES | NO |
|--|--------------------------|--|
| ☐ Hospital Bed (Answer B) | ☐ | ☐ A) Is the patient bed confined? |
| ☐ Hospital Bed—Variable Height (Answer B) | ☐ | ☐ B) Does the patient's condition require positioning of the body or attachments which would not be feasible with the use of an ordinary bed? |
| ☐ Electric Hospital Bed (Answer C, D) | ☐ | ☐ C) Does the patient's condition require frequent and/or immediate changes in body position? |
| ☐ Side Rails (Answer E) | ☐ | ☐ D) Can the patient operate the controls himself? |
| ☐ Commode—Standard (Answer A, F, N) | ☐ | ☐ E) Is the patient disoriented at any time? |
| ☐ Commode—Adjustable (Answer A, F, N) | ☐ | ☐ F) Is the patient room confined? |
| ☐ Trapeze Bar (Answer A, G, H) | ☐ | ☐ G) Is there a need for the patient to sit up due to a respiratory condition, etc.? |
| ☐ Alternating Pressure Pad (Answer I, J) | ☐ | ☐ H) Is there a medical need for a change in body position? |
| ☐ Wheelchair—Standard (Answer K) | ☐ | ☐ I) Is the patient susceptible to decubitus ulcers? |
| ☐ Wheelchair with Elevating Legrests (Answer K) | ☐ | ☐ J) Are you supervising the use of pressure pad? |
| ☐ Walker (Answer L, M) | ☐ | ☐ K) Is the patient's condition such that the alternative would be bed or chair confinement? |
| ☐ Walker—Folding (Answer L, M) | ☐ | ☐ L) Does the patient's condition impair ambulation? |
| ☐ Walker—Adjustable (Answer L, M) | ☐ | ☐ M) Is the walker used for therapy? |
| ☐ Cane (Answer L, M) | ☐ | ☐ N) Is the patient confined to floor without bathroom facilities? |
| ☐ Quad Cane (Answer L, M) | ☐ | |

If ambulatory equipment such as a walker, cane or quad cane is being used with non-ambulatory equipment such as side rails, trapeze bar etc., please explain why both are medically necessary.

Items not included above and diagnosis or condition which warrants equipment.

5-7-90

E0650 Compression Boot Motor Restricted ambulation due to fluid in legs.
E0660 (2) Full Legs.

If equipment is not used in patient's home, please indicate the name and address of the facility where the patient resides. (Print or type)

IMPORTANT: This form must be signed and dated by prescribing physician before the equipment may be considered for payment (Print or type).

Physician's Name Dr. Bell
872-8040

Physician's Phone No. Crozier Chester Med. Ctr.
15th & Upland St.

Physician's Address Chester, Pa. 19015

Physician's Signature _____

Date _____

Dr.'s. Medicare I.D.# _____

SIGNATURE OF THE PHYSICIAN CERTIFIES THAT THE ABOVE REPRESENTS HIS JUDGEMENT OF THE PATIENT'S NEED FOR THE EQUIPMENT

Pennsylvania
Blue Shield



Medicare

Camp Hill, PA 17011

Prescription For:
☒ Initial
☐ Recertification
☐ Exchange of Equipment

ALLSTATE MEDICAL EQUIP., INC.
2 RYERS AVENUE
CHELTENHAM, PA 19012

Form Approved OMB No. 0938

Certificate of Medical Necessity

Medicare regulations require the following information be provided on claims for durable medical equipment. This form should be complete by the beneficiary's physician and returned to us with a completed Medicare claim form.

Patient's Name Marquette Lord Health Insurance Claim No. 195-05-1287D

Diagnosis _____ Date this equipment prescribed 5-7-90 Equipment will be needed for 36 months. Prognosis Good

This prescription applies to rental period from Month 5 Day 7 Year 90 to Month _____ Day _____ Year _____

Please check the equipment you are prescribing and answer YES or NO to the corresponding question. Equipment with special attachment or features, or equipment not included below should be listed in the space provided.

- | | YES | NO | |
|--|--------------------------|--------------------------|---|
| ☐ Hospital Bed (Answer B) | ☐ | ☐ | A) Is the patient bed confined? |
| ☐ Hospital Bed—Variable Height (Answer B) | ☐ | ☐ | B) Does the patient's condition require positioning of the body or attachments which would not be feasible with the use of an ordinary bed? |
| ☐ Electric Hospital Bed (Answer C, D) | ☐ | ☐ | C) Does the patient's condition require frequent and/or immediate changes in position? |
| ☐ Side Rails (Answer E) | ☐ | ☐ | D) Can the patient operate the controls himself? |
| ☐ Commode—Standard (Answer A, F, N) | ☐ | ☐ | E) Is the patient disoriented at any time? |
| ☐ Commode—Adjustable (Answer A, F, N) | ☐ | ☐ | F) Is the patient room confined? |
| ☐ Trapeze Bar (Answer A, G, H) | ☐ | ☐ | G) Is there a need for the patient to sit up due to a respiratory condition, etc.? |
| ☐ Alternating Pressure Pad (Answer I, J) | ☐ | ☐ | H) Is there a medical need for a change in body position? |
| ☐ Wheelchair—Standard (Answer K) | ☐ | ☐ | I) Is the patient susceptible to decubitus ulcers? |
| ☐ Wheelchair with Elevating Legrests (Answer K) | ☐ | ☐ | J) Are you supervising the use of pressure pad? |
| ☐ Walker (Answer L, M) | ☐ | ☐ | K) Is the patient's condition such that the alternative would be bed or chair confinement? |
| ☐ Walker—Folding (Answer L, M) | ☐ | ☐ | L) Does the patient's condition impair ambulation? |
| ☐ Walker—Adjustable (Answer L, M) | ☐ | ☐ | M) Is the walker used for therapy? |
| ☐ Cane (Answer L, M) | ☐ | ☐ | N) Is the patient confined to floor without bathroom facilities? |
| ☐ Quad Cane (Answer L, M) | ☐ | ☐ | |

If ambulatory equipment such as a walker, cane or quad cane is being used with non-ambulatory equipment such as side rails, trapeze etc., please explain why both are medically necessary.

Items not included above and diagnosis or condition which warrants equipment. 5-7-90
E0235 Paraffin Wax Bath If after 30 day successful trial period
condition is expected to be relieved by long term use of modality

If equipment is not used in patient's home, please indicate the name and address of the facility where the patient resides. (Print or type)

IMPORTANT: This form must be signed and dated by prescribing physician before the equipment may be considered for payment. (Print or type)

Physician's Name Dr. Jeffrey Bell

Physician's Phone No. Crozier Chester Med. Ct.

Physician's Address 15th & Spind St.

Chester, Pa. 19015

Physician's Signature [Signature]

Date _____

Dr.'s Medicare I.D.# _____

MCB 8 687

ALLSTATE MEDICAL EQUIPMENT, INC.

2 Ryers Avenue • Chesham, PA 19012 • (215) 863-8200

Dear Dr. *Bell*

Enclosed are Medical Necessity Forms regarding your patient

Daniel Fawcett. We have advised the patient
that we must have your consent for Medical Equipment.

When filling in the forms please make sure you include the following:

DIAGNOSIS & PROGNOSIS

A PRESCRIPTION FOR EACH ITEM

YOUR MEDICARE I.D.#

SIGNATURE & DATE

Medicare requires all of the above items to be on forms.

Thanking you in advance, we remain

Sincerely,

ALLSTATE MEDICAL EQUIPMENT, INC.

Pennsylvania
Blue Shield



Medicare

Camp Hill, PA 17011

ALLSTATE MEDICAL EQUIP., INC.
2 RYERS AVENUE
CHELTENHAM, PA 19012

Form Approved OMB No. 0938-0

Prescription For:
☐ Initial
☐ Recertification
☐ Exchange of Equipment

Certificate of Medical Necessity

Medicare regulations require the following information be provided on claims for durable medical equipment. This form should be completed by the beneficiary's physician and returned to us with a completed Medicare claim form.

Patient's Name Daniel Faverio Health Insurance Claim No. 168 12 1033 A

Diagnosis _____

Date this equipment prescribed 8-9-90 Equipment will be needed for 36 months. Progression _____

This prescription applies to rental period from Month 8 Day 9 Year 90 to Month _____ Day _____ Year _____

Please check the equipment you are prescribing and answer YES or NO to the corresponding question. Equipment with special attachment or features, or equipment not included below should be listed in the space provided.

- | | YES | NO | |
|--|--------------------------|--------------------------|---|
| ☐ Hospital Bed (Answer B) | ☐ | ☐ | A) Is the patient bed confined? |
| ☐ Hospital Bed—Variable Height (Answer B) | ☐ | ☐ | B) Does the patient's condition require positioning of the body or attachments which would not be feasible with the use of an ordinary bed? |
| ☐ Electric Hospital Bed (Answer C, D) | ☐ | ☐ | C) Does the patient's condition require frequent and/or immediate changes in bed position? |
| ☐ Side Rails (Answer E) | ☐ | ☐ | D) Can the patient operate the controls himself? |
| ☐ Commode—Standard (Answer A, F, N) | ☐ | ☐ | E) Is the patient disoriented at any time? |
| ☐ Commode—Adjustable (Answer A, F, N) | ☐ | ☐ | F) Is the patient room confined? |
| ☐ Trapeze Bar (Answer A, G, H) | ☐ | ☐ | G) Is there a need for the patient to sit up due to a respiratory condition, etc.? |
| ☐ Alternating Pressure Pad (Answer I, J) | ☐ | ☐ | H) Is there a medical need for a change in body position? |
| ☐ Wheelchair—Standard (Answer K) | ☐ | ☐ | I) Is the patient susceptible to decubitus ulcers? |
| ☐ Wheelchair with Elevating Legrests (Answer K) | ☐ | ☐ | J) Are you supervising the use of pressure pad? |
| ☐ Walker (Answer L, M) | ☐ | ☐ | K) Is the patient's condition such that the alternative would be bed or chair confinement? |
| ☐ Walker—Folding (Answer L, M) | ☐ | ☐ | L) Does the patient's condition impair ambulation? |
| ☐ Walker—Adjustable (Answer L, M) | ☐ | ☐ | M) Is the walker used for therapy? |
| ☐ Cane (Answer L, M) | ☐ | ☐ | N) Is the patient confined to floor without bathroom facilities? |
| ☐ Quad Cane (Answer L, M) | ☐ | ☐ | |

If ambulatory equipment such as a walker, cane or quad cane is being used with non-ambulatory equipment such as side rails, trapeze bar, etc., please explain why both are medically necessary.

Items not included above and diagnosis or condition which warrants equipment.

8-9-90
80730 Tens Unit if after trial period it's been found helpful in
relieving chronic intractable pain not relieved by conventional
methods.

If equipment is not used in patient's home, please indicate the name and address of the facility where the patient resides. (Print or type.)

SIGNATURE OF THE PHYSICIAN CERTIFIES THAT THE ABOVE REPRESENTS HIS JUDGEMENT OF THE PATIENT'S NEED FOR THE EQUIPMENT.

UCSAS R 007

IMPORTANT: This form must be signed and dated by prescribing physician before the equipment may be considered for payment (Print or type.)

Physician's Name _____

Physician's Phone No. _____

Physician's Address _____

Physician's Signature _____

Date _____

Dr.'s. Medicare I.D.#. _____

Pennsylvania
Blue Shield



Medicare

Camp Hill, PA 17011

ALLSTATE MEDICAL EQUIP., INC.
2 RIVERS AVENUE
CHELTENHAM, PA 19012

Form Approved OMB No. 0538-0213

Prescription For:
☒ Initial
☐ Recertification
☐ Exchange of Equipment

Certificate of Medical Necessity

Medicare regulations require the following information be provided on claims for durable medical equipment. This form should be completed by the beneficiary's physician and returned to us with a completed Medicare claim form.

Patient's Name Daniel Paverio Health Insurance Claim No. 168 12 1033 A

Diagnosis _____

Date this equipment prescribed 8-9-90 Equipment will be needed for 35 months. Prognosis _____

This prescription applies to rental period from Month 8 Day 9 Year 90 to Month _____ Day _____ Year _____

Please check the equipment you are prescribing and answer YES or NO to the corresponding question. Equipment with special attachments, or features, or equipment not included below should be listed in the space provided.

- | | YES | NO | |
|--|--------------------------|--------------------------|---|
| ☐ Hospital Bed (Answer B) | ☐ | ☐ | A) Is the patient bed confined? |
| ☐ Hospital Bed—Variable Height (Answer B) | ☐ | ☐ | B) Does the patient's condition require positioning of the body or attachments which would not be feasible with the use of an ordinary bed? |
| ☐ Electric Hospital Bed (Answer C, D) | ☐ | ☐ | C) Does the patient's condition require frequent and/or immediate changes in body position? |
| ☐ Side Rails (Answer E) | ☐ | ☐ | D) Can the patient operate the controls himself? |
| ☐ Commode—Standard (Answer A, F, N) | ☐ | ☐ | E) Is the patient incontinent at any time? |
| ☐ Commode—Adjustable (Answer A, F, N) | ☐ | ☐ | F) Is the patient room confined? |
| ☐ Trapeze Bar (Answer A, G, H) | ☐ | ☐ | G) Is there a need for the patient to sit up due to a respiratory condition, etc.? |
| ☐ Alternating Pressure Pad (Answer I, J) | ☐ | ☐ | H) Is there a medical need for a change in body position? |
| ☐ Wheelchair—Standard (Answer K) | ☐ | ☐ | I) Is the patient susceptible to decubitus ulcers? |
| ☐ Wheelchair with Elevating Legrests (Answer K) | ☐ | ☐ | J) Are you supervising the use of pressure pad? |
| ☐ Walker (Answer L, M) | ☐ | ☐ | K) Is the patient's condition such that the alternative would be bed or chair confinement? |
| ☐ Walker—Folding (Answer L, M) | ☐ | ☐ | L) Does the patient's condition impair ambulation? |
| ☐ Walker—Adjustable (Answer L, M) | ☐ | ☐ | M) Is the walker used for therapy? |
| ☐ Cane (Answer L, M) | ☐ | ☐ | N) Is the patient confined to floor without bathroom facilities? |
| ☐ Quad Cane (Answer L, M) | ☐ | ☐ | |

If ambulatory equipment such as a walker, cane or quad cane is being used with non-ambulatory equipment such as side rails, trapeze bar, etc., please explain why both are medically necessary.

Items not included above and diagnosis or condition which warrants equipment. 8-9-90

R0215 Water heating pad To relieve pain of arthritis for long
period of time

Z1825 (2) Binged knee support Therapeutically necessary

If equipment is not used in patient's home, please indicate the name, and address of the facility where the patient resides. (Print or type.)

IMPORTANT: This form must be signed and dated by prescribing physician before the equipment may be considered for payment (Print or type.)

Physician's Name _____

Physician's Phone No. _____

Physician's Address _____

Physician's Signature _____

Date _____

Dr.'s. Medicare I.D.# _____

SIGNATURE OF THE PHYSICIAN CERTIFIES THAT THE ABOVE REPRESENTS HIS JUDGEMENT OF THE PATIENT'S NEED FOR THE EQUIPMENT.

MOED R 617

ALLSTATE MEDICAL EQUIPMENT, INC.

2 Ryers Avenue • Cheltenham, PA 19012 • (215) 683-9200 • 1-800-838-4545Dear *Daniel Ferrell*,

Please take this Certificate of Medical Necessity with you to your next appointment with your doctor. In order for our company to provide you with any Durable Medical Equipment (DME) we must have a physician's approval. If your doctor feels that you will benefit from using the requested "DME", have the doctor review and sign this form, and then you can return it to us. If the doctor feels that there is no documented need for the equipment, please call us at the above telephone number and let us know so that we may close your file.

Thank you for dealing with Allstate Medical Equipment, Inc. We hope that you will be satisfied with our services.

Sincerely,

ALLSTATE MEDICAL EQUIPMENT, INC.

JEFFREY M. BELL, M. D.

SUITE 106
CCMC PROFESSIONAL BUILDING
15TH STREET AND UPLAND AVENUE
UPLAND, CHESTER, PENNSYLVANIA • 19013
(215) 872-8040

STEPHEN D. CONRAD, M. D.

6/11/91

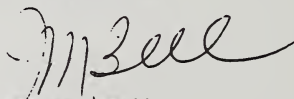
To Whom It May Concern:

This is to inform you that I had been signing and filling our medical equipment forms that I assumed were coming from Medicare. I thought that all of these requests were being made be the visiting nurse or the patient's family. It became clear to me after a patient brought this to my attention that medical companies were soliciting elderly patients and telling them that they were eligble for such articles that were totally un-necessary.

Since this has been brought to my attention I am very careful of any and all forms received by my office from any medical companies.

It is my concern that too many elderly people have received equipment and Medicare has paid for equipment that is totally un-necessary.

Sincerely,



Jeffrey M. Bell, M.D.

JMB/jf

Chairman PICKLE. Does that complete your statement?

Dr. BELL. Yes, and I would be delighted to answer any questions.

Chairman PICKLE. Ms. Fidale, would you want to add any comments to his statement?

Ms. FIDALE. No. I would go along with Dr. Bell that the logo I think threw us completely at the top of the page.

Chairman PICKLE. The next witness will be Herbert N. Levin.

Mr. Levin.

STATEMENT OF HERBERT N. LEVIN, PHILADELPHIA, PA

Mr. LEVIN. Gentlemen, I used to work as a delivery man for a durable medical equipment supplier in the Philadelphia area. I worked for the company for about 6 weeks delivering equipment to senior citizens.

The owner of the company gave me the title of medical technician. The problem was that I had no training in the use of the equipment that I was taking to the people. I was just supposed to watch how other employees handled the deliveries and learn from them. Although I asked the owner some questions, I really ended up taking the equipment home myself to read the instructions and learn on my own. I wanted to know something about the equipment I was delivering and selling. I did not know whether some of it could hurt someone, and I was bothered by the fact that I was being called a medical technician.

The equipment had been ordered by senior citizens who had been called by a group of young girl employees of the company. These girls sat at telephones with lists of names in front of them and just called down the list—a real boiler room operation.

Deliveries followed a normal pattern. First one of the girls at the office would call the senior citizen and announce the delivery time. When I arrived at the door I knocked and yelled "Medicare." The owner told me to say this because it would get their attention. Often the front door would already be open because they were waiting for me to arrive.

Once inside, I would deliver the equipment and ask the person to sign a form showing that they received it. About half the time people would tell me that they did not want the equipment and would explain that they had already told the girl that on the phone.

Then I would show them the Medicare form where their doctor actually signed it and tell them that the doctor would not have signed it if he did not believe they really needed the equipment. After that the person generally accepted the delivery.

At that point I was supposed to try to push what we called add-ons—different pieces of equipment that the girl in the office would identify as needed by the senior citizen after she spoke to them initially.

There were different categories for different ailments. If the person told the girl about his arthritis, it was my responsibility to try to sell them on the idea that they needed equipment for that ailment. Since I had already introduced myself as a medical technician, I would explain that these things would be helpful for their condition. Lying was part of my job.

The add-ons were important to the girls in the office because each add-on meant bonus points, and bonus points meant extra cash for the girls and myself, although I never received any of the money that I was promised. This was not a situation where items were being recommended based on someone's medical knowledge or individual need. It was strictly for dollars.

The owner was also keeping track of my success in pushing add-ons and would question me about any lack of success I had in this area. However, I convinced a lot of people to take that extra equipment. I can be fairly persuasive.

I also watched how the owner pushed these add-ons. He would actually threaten people. I remember one older person who told me that he did not want the delivery. The owner was in the truck at the time, and he got out and said to the man look, this stuff was ordered by your doctor. If you do not take this you may need something later, and you probably will not get it. Then the owner turned to me and said this is how it is done.

I remember another time when we were supposed to deliver a hospital bed to a lady's home. We had to carry the hospital bed up at least two flights of stairs. When we got to where we were supposed to put the bed, I discovered that the lady already had a hospital bed. She said that it was not working, but I found out that the plug just was overloaded. I plugged it in elsewhere, and it worked fine.

We took the new bed back, but that was a big mistake. We caught hell from the owner for not replacing the old bed with the new one. The next day we ended up delivering the new bed and bringing the old one back.

Sometimes we picked up used equipment and charged to clean it up so that it could be delivered to someone else. One time there was an old vinyl-covered mattress that was not cleaned. The owner told me do not bother. We will give that to the black people in north Philadelphia. I took from that statement that we were going to pass this stuff off as new equipment to black people in north Philadelphia. Sometimes used equipment was actually put into new boxes to appear unused.

People would often call and ask the company to pick up equipment they were finished with or that they did not want. I know that the owner would not authorize an item to be picked up until Medicare had totally paid for the item. If someone called and wanted an item picked up that the company could collect Medicare payments for another 5 or 6 months, it was simply left there.

I appreciate the opportunity to appear before the committee. I would be happy to respond to any questions. Thank you.

Chairman PICKLE. Thank you, Mr. Levin, for a good statement.

Now the Chair may proceed to inquire of any of the witnesses. The Chair would recognize Mr. Schulze first.

Mr. Schulze.

Mr. SCHULZE. Thank you, Mr. Chairman. Mrs. Kantner, did they ask for your Medicare number when they called and talked to you?

Ms. KANTNER. Yes, she took all my insurance information, my Medicare and Blue Cross/Blue Shield.

Mr. SCHULZE. What did she say when you answered the phone? How did she gain your confidence? You did not believe that this

was an operation trying to sell you something at first? Is that correct?

Ms. KANTNER. Oh, no. She first announced who she was, but she said a neighbor of mine had said that I had arthritis. In fact, she asked this other woman if she had any friends. She gave my name, and she called me. Otherwise I would have hung up right away. When somebody calls you by name and you think a friend has recommended, you listen.

Mr. SCHULZE. She asked for your number. What other information did she ask for?

Ms. KANTNER. At that time she just took my insurance information and my doctor's name.

Mr. SCHULZE. Allstate sent you a heating pad. Did you already have a heating pad?

Ms. KANTNER. Yes, I did.

Mr. SCHULZE. So even if you had known or had been asked, you would have said no, I do not need a heating pad because I already have one?

Ms. KANTNER. That is right.

Mr. SCHULZE. Did your doctor sign the form approving the purchase or the delivery of this equipment?

Ms. KANTNER. That I do not know. When I visited him on July 19 I told him about all this. He said well, I thought you wanted it. Whether they got a verbal acceptance or just a rubber stamp from him, I do not know.

Mr. SCHULZE. Mrs. Kantner, where is this equipment now?

Ms. KANTNER. It is up on my second floor covered up. It has been there ever since August waiting for them to come get it.

Mr. SCHULZE. Thank you. Ms. Robinson, I thank you for appearing today. When they called you they said they were updating their records again. It seems to me an important part of this is gaining your confidence somehow so that you will give them information. Can you tell me how they did that?

Ms. ROBERTSON. They just simply stated we are updating your Medicare. I very foolishly assumed this was an official call from gosh, I do not know, President Bush. I answered a few simple questions. I do not remember what they were, but they were very simple and very short-lived.

Mr. SCHULZE. You also gave them your Medicare number?

Ms. ROBERTSON. I am certain I did.

Mr. SCHULZE. I understand you are quite an active person. Do you still play tennis?

Ms. ROBERTSON. Yes, as of yesterday.

Mr. SCHULZE. So it did not really make an awful lot of sense to you to have this kind of equipment?

Ms. ROBERTSON. No, it did not. In fact, they tried to go further. They said I needed a hospital bed and a wheelchair, and they also said I did not have bathroom facilities on my floor.

Mr. SCHULZE. I must say that it would have been easy for you to let this slide, and I would like to congratulate you on having the fortitude to just not let this pass but to actively do something about it.

Ms. ROBERTSON. Thank you.

Mr. SCHULZE. You are to be congratulated.

Dr. Bell, what do you do now when these forms come across your desk, or do they no longer come across your desk?

Dr. BELL. They still come. We have to stop and look and really look at each and every one. In fact, I was talking with my staff. There are a couple that are truly necessary that are still on my desk, and I am waiting to review them and make sure that all the equipment—it is for a hospital bed—is justified.

We just started collecting, and I think I have eight or nine that I brought since I reported this first one to Mr. Baxter at Blue Cross. We go through each and every one. I would just say that I cannot imagine that the numbers of these that go through every doctor's office, I could not imagine what the number is.

Mr. SCHULZE. How many do you receive on an average?

Dr. BELL. Twenty a month. I am making that number up as I am just sort of trying to get some idea, but I know that other physicians would go through these, make certain that they were not denying someone something that their patients needed and just sign signed statements.

We have brought five or six of them. We have contacted each of these patients, and they were things that again were unnecessary. As everyone has mentioned, they say well, I thought my doctor wanted it or I thought my doctor ordered it. That has to be going on in a grand fashion.

Mr. SCHULZE. I presume there are legitimate occasions upon which you recommend the utilization of some of this type of equipment?

Dr. BELL. Of course. The time that that would happen, again, would be with a patient that was being cared for through, say, hospice or home care. The nurse would call and say I think we are going to need a hospital bed. In that case and in that situation it is easy, but you cannot always remember that you had that communication.

Chairman PICKLE. Dr. Bell, you just stated that you probably receive approximately 20 requests a month to sign these certificates. Is that still an ongoing figure each month now? You get approximately 20 requests a month for this type of equipment?

Dr. BELL. Yes, it is. Again, there are legitimate requests.

Chairman PICKLE. I understand that. If you get 20 a month is that also typical, in your judgement, of other physicians who are practicing?

Dr. BELL. Absolutely.

Chairman PICKLE. So it is not just an isolated case?

Dr. BELL. Absolutely. It is not.

Chairman PICKLE. It is anybody who practices medicine?

Dr. BELL. Yes. There is nothing particular about my practice that would make it be any more or less than other physicians practicing in the area.

Chairman PICKLE. How long have you practiced here in this area?

Dr. BELL. Since 1975.

Mr. SCHULZE. Dr. Bell, before I go further, let me thank you for taking time from your practice to come here today. I appreciate the effort very much.

It seems to me that the physician is a choke point at which some of this can be stopped.

If you were given a free reign in deciding how that could be done or should be done, what recommendations would you make?

Dr. BELL. Well, I am not sure. One of the things that I would try to have you not do is put another burden on the physician who already feels that he is "over-burdened" and one more situation of look what you have done wrong.

Certainly the allowance of the forms, this is a gross misjustice, the forms that I have asked you to look at. There is no way that a meaningful health worker would look at that and not know. The form that is sent out looks very appropriate. It looks very proper. There is just no right. Allstate Medical Equipment should not be using the Medicare logo or any company. That is the first place I would stop. That has to be stopped.

One of the things we are trying to do is see if we can have the home care and the community nursing service deal with one dealership in the area that we know and that we can call or that we know people with whom we can talk and say how did the request for this get generated. That is helpful.

The other is to bring it to everyone's attention so this will stop.

Mr. SCHULZE. How about the county medical organizations? Is there not a way that they could be alerted to this and have doctors give greater scrutiny to the applications that come across their desks?

Dr. BELL. I do not think that that is a way where anything effective would occur.

Mr. SCHULZE. You do not?

Dr. BELL. No.

Mr. SCHULZE. Let me ask you a question that you may not want to answer because there have been inferences that there might be cases where doctors would receive some sort of kick-back or pay-off or some kind of a fee or gratuity or vacation or something in return for signing a great number of these.

Have you ever heard anything like that or even any inferences of that?

Dr. BELL. I have never heard anything like that. I think the major problem for most physicians is they will get a significant number of these, and the last thing they want to deal with is more forms, more questions or requests from companies, so they will just sign them.

I think it is more as it was with me—a function of a lack of looking at it; not so much laziness, but just not wanting to have to bother with the paperwork.

Mr. SCHULZE. Dr. Bell, how did this first come to your attention?

Dr. BELL. As I said, one of our patients called with a great deal of concern. My sense was that she was worried that there was something wrong with her that she did not know about. She called and spoke to our staff, particularly to Joan, and said why did Dr. Bell order this equipment for me. We looked at that, and I went back. I said who signed this? The who was me. I signed it, again not realizing what I had done.

At that point we got to her, and as I mentioned, we called Mr. Baxter and asked him what it is a person has to do to undo this,

that this was fraudulent and that I was part of this—unknowingly—fraudulent scheme.

Mr. SCHULZE. Thank you, doctor.

Mr. LEVIN, how were the lists generated? As you described it it sounded to me like what they used to call a boiler room operation where they had people just sitting in a little room making phone calls. If it is that type of operation, how are the lists generated of the people who are called?

Mr. LEVIN. I could not actually respond as to how they obtained their lists. I would say or suggest that as other lists are available in business for all categories of business, so indeed is a list of the citizens who are 55 and over. I do not think it is much more complicated than that.

Mr. SCHULZE. They were just buying or securing somewhere lists of senior citizens?

Mr. LEVIN. I think so.

Mr. SCHULZE. Would you describe the telephone solicitation as a boiler room type?

Mr. LEVIN. Well, it is called telemarketing today, as you know, Mr. Schulze. It is certainly from the old school a boiler room operation. While that does not have a very good connotation, certainly that is a big business in our country today. Telemarketing is very, very important to a lot of industries.

Nevertheless, yes, it is a group of gals who are paid an hourly rate to dial a number, introduce themselves, have a basic canned pitch of who they are and the reason they are calling. It is really not very difficult. It does not take any skill.

Mr. SCHULZE. Why did the company routinely wait so long to pick up items after the beneficiaries complained?

Mr. LEVIN. Money.

Mr. SCHULZE. Explain that.

Mr. LEVIN. Well, the government allows them to lease an item to a client for a certain period of time. It just would not make much sense from the standpoint of getting that income when someone would call up and say we have no need for this now. It was delivered last week.

I think she alluded to the fact that it was a gel mattress. I do not remember exactly what the profit structure is on that, but nevertheless, no DME company is going to pick that up until that time has expired. Then it has been paid for. Now it is all a free ride. Now when they pick it up and use it over for someone else's need, it just goes on and on.

Mr. SCHULZE. In other words, when this item is delivered and the individual calls and says I either do not need it or no longer need it, they wait to pick it up until after the length of time that it would take for the rental to pay for the cost of the item?

Mr. LEVIN. And the profit.

Mr. SCHULZE. And the profit.

Mr. LEVIN. Sure.

Mr. SCHULZE. How was the quality of the equipment that you delivered?

Mr. LEVIN. I suppose the best way to respond to that is to say that it is a business, and a businessman buys the product as inex-

pensively as he can. His profit structure is set. He knows what the government is paying for that product that is used.

I think you mentioned or someone else mentioned about a TENS unit. TENS units are manufactured by numerous people. Some are more expensive than others. Some are cheaper than others. In essence, supposedly they all do the same thing. The ones that cost more do it a little better.

Mr. SCHULZE. Was your experience that they had the entire range, the expensive units and the inexpensive units, or did they just strive to buy the least expensive unit that they could possibly find?

Mr. LEVIN. There does not seem to be any control over what products they buy. As long as they are able to supply a moist heating pad the moist heating pad, no matter who it is manufactured by, they can buy from whomever they want to buy it from.

Mr. SCHULZE. Mr. Levin, can you tell us about the paraffin wax wraps that were repackaged?

Mr. LEVIN. Paraffin wax is a canister—sort of a parallelogram. It is about a foot and a half long and maybe 7 or 8 inches wide. It is completely enclosed in a plastic cover, and then it is put inside a box. This is obviously because of cleanliness and so on. It is new.

When that product is delivered and after it is used it is one of the products that is also on a lease or rental, and it is picked up after it is used. It is brought back, at least by this company, and reused again. Now, in order to make it appear as if it is still sanitary, if you will, they take a new one out of a box and put the old one into a new box. It is delivered that way.

Mr. SCHULZE. Thank you.

Chairman PICKLE. Would you yield temporarily? The committee would like to receive a description of some of the equipment here on the table. We were privileged earlier to have some of this pointed out by what it would cost.

Who on the staff or the inspector general's office perhaps can explain this equipment and give us some background on it? Would you come forward and identify yourself?

STATEMENT OF PAT GILMORE, INVESTIGATOR, INSPECTOR GENERAL'S OFFICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. GILMORE. My name is Pat Gilmore. I am with the Inspector General's Office, Department of Health and Human Services.

We brought some examples of some of the equipment that people have received from these telemarketing companies. This is the paraffin wax bath that Mr. Levin was just describing. It is a box filled with wax. It has to be heated up for about 7 to 9 hours. The temperature, once it is heated up, gets to about 140 degrees.

The purpose of this is to relieve arthritic pain. The person is supposed to stick their hand in it or their elbow or their foot or whatever part of their body has pain and take it out immediately. The heat remains on your body, and it is supposed to relieve the pain.

The problem is that if a senior citizen has peripheral vascular disease or some other problem with feeling in their extremities and they do not feel the heat they can burn themselves. Also, this is

the packet of instructions that they get. If they get no instruction from their doctor they would not necessarily know that they have to take their hand out of the wax and not leave it in there and thereby burn themselves.

Chairman PICKLE. Ms. Gilmore, let me interrupt you. Hold it up so the committee may see that. That is a paraffin wax bath.

Ms. GILMORE. Paraffin wax bath.

Mr. SCHULZE. That has heating elements down inside it?

Ms. GILMORE. Yes. It plugs in and has heating elements underneath it.

Chairman PICKLE. What did that wax equipment cost from the supplier?

Ms. GILMORE. It cost the supplier about \$95.

Chairman PICKLE. \$95. What does Medicare pay for it, Blue Cross/Blue Shield?

Ms. GILMORE. In Pennsylvania this sold for \$518.64.

Chairman PICKLE. Say that again.

Ms. GILMORE. \$518.64. If the company also collected coinsurance or collected from the beneficiary, it would be \$648.30.

Chairman PICKLE. In essence it cost \$95 approximately, and Medicare reimburses it for \$518.64?

Ms. GILMORE. That is correct.

Chairman PICKLE. All right. Go right ahead.

Mr. SCHULZE. Is that the reimbursement for the current year?

Ms. GILMORE. This is 1990.

Dr. BELL. Mr. Chairman, I wonder if I may add something? There is also very little evidence that these baths do anything or offer any help to anybody other than temporary, very minimal relief. There really is no good medical use for these things, this paraffin bath.

Chairman PICKLE. If they are of no use medically, yet when they call the doctor's office a doctor must sign that that is needed?

Dr. BELL. That is right, and the doctor will do it because again, if someone generated the idea he will say well, it is arthritis and there is not an awful lot I can do. The family wants it or someone else thought it might be a good idea.

I just wanted to add in addition to the very important safety things, it is a very expensive item that offers almost minimal medical help.

Chairman PICKLE. Thank you. Go ahead.

Ms. GILMORE. This is a TENS unit that I believe one of the witnesses described as getting. It is an electrical nerve stimulator. The purpose of it is to block the sensation of pain. It is battery operated, and it has leads on it. You put the pads on the area of your body where you experience the pain, and it is supposed to relieve pain.

A TENS unit could be dangerous. If you have a pacemaker, for example, it could interfere with the operation of the pacemaker. This item may or may not have good medical use and should always be used only under the supervision of a doctor. It should not be delivered to someone when they are left to figure out how it should be used.

Chairman PICKLE. Ms. Gilmore, what does that TENS container cost?

Ms. GILMORE. This could run anywhere from \$49.99 to maybe—
Chairman PICKLE. I beg your pardon? How much?

Ms. GILMORE. Maybe \$49 or \$50 up to about \$80. It is reimbursed around \$400 to \$500.

Chairman PICKLE. And Medicare reimburses for it?

Ms. GILMORE. Yes.

Chairman PICKLE. It costs \$49 or \$50 roughly, and Medicare reimburses at \$500.

Dr. Bell, is that TENS equipment beneficial? Helpful? Any good?

Dr. BELL. There is now a controlled study that shows that these are also useless.

Chairman PICKLE. They are what?

Dr. BELL. Useless.

Chairman PICKLE. Not any good?

Dr. BELL. Of no use. TENS units were of no use and did not make any significant difference.

Chairman PICKLE. Thank you.

Ms. GILMORE. This was billed as a flotation pad for a wheelchair. The purpose of this equipment and the other two pieces of equipment that we have to show you are all supposedly to prevent bed sores. They are intended for people who are either chair or wheelchair confined and the mattresses if they are bed confined for any length of time.

This particular pad cost the supplier \$23.49. Medicare reimburses at \$192.77.

Chairman PICKLE. It costs \$22, and it is reimbursed at \$192?

Ms. GILMORE. Yes. Again, if the beneficiary paid the coinsurance amount, the 20 percent, it would be \$240.96.

Chairman PICKLE. All right.

Ms. GILMORE. This item here is basically made out of the same material as the one I just showed you. It is a mattress for a bed. A dry flotation mattress is the description of it. The costs the supplier \$28.50, and Medicare reimbursement was \$241.64.

Chairman PICKLE. Cost is \$28, and Medicare reimburses for what?

Ms. GILMORE. \$241.64. It is interesting to note that the carrier in New York reimbursed \$943.43 for the same piece of equipment. That has since been changed, but that was the 1990 reimbursement rate.

This piece of equipment here, as you can see, it fell apart. It was billed as a decubitus care mattress, which is supposed to be actually a better quality mattress than this that I just showed you. It fell apart because when it gets cold the piece of foam gets stiff from being unrolled and rolled back up again and put in the box. It just broke it to pieces.

This comes on a roll of foam. It is just cut off to the size that you want. It costs the supplier about \$50, and in Pennsylvania it was reimbursed at \$726.12.

Chairman PICKLE. I want to be sure I understand that. It costs around \$50, and Pennsylvania reimburses at what rate?

Ms. GILMORE. \$726.12.

Chairman PICKLE. \$726? Holy mackerel.

Ms. GILMORE. This is a heating pad. It is a standard heating pad. It was described as a moist heating pad. They inserted a piece of

felt within the heating pad which can be moistened. This item cost the supplier \$9.68 and was reimbursed by Medicare at \$53.03.

Chairman PICKLE. What was the cost again?

Ms. GILMORE. \$9.68.

Chairman PICKLE. And reimbursed at what rate?

Ms. GILMORE. \$53.03. Again, to show the difference between what different carriers pay for the same item, if this were billed in New York it would be reimbursed at \$14.68 for the same piece of equipment. There is no standardization between one carrier and another.

The last items we have here are knee braces, which are simply elastic Ace-type braces. These cost the supplier about \$4.95. One of them was reimbursed at \$29.17 in Pennsylvania. It is our experience that they are always sold in pairs, so you would normally just double the figure. They always send two knee braces to a beneficiary.

Chairman PICKLE. That is a knee brace? Do they always sell them as pairs?

Ms. GILMORE. Yes, they always send two.

The last thing is a back brace. This back brace is a standard type you could buy at a drug store. It is elastic. It has a velcro closure on it. They come, as with the knee braces, in sizes small, medium and large. Normally they are billed as either a custom-fitted or custom-fabricated back brace. This particular one cost the supplier \$14.85, and it was reimbursed at \$73.69.

Chairman PICKLE. Thank you very much, Ms. Gilmore, for demonstrating the equipment and the uses. Before you leave would you tell the committee who sets the price for reimbursement here in Pennsylvania?

Ms. GILMORE. The reimbursement is based on how much is generally charged for the equipment. In effect, the suppliers are the ones who set the fee structure, because it has to do with what they usually charge for the equipment.

Chairman PICKLE. In other words, if there are 50 or 100 suppliers and if their rate on the average is that much of an increase, whatever that average is would be the price rather than whether it is worth it?

Ms. GILMORE. That is a simplified explanation, but basically yes, that is it.

Chairman PICKLE. Thank you very much. Mr. Schulze, would you want to continue with any other questions?

Mr. SCHULZE. I am just about finished, Mr. Chairman. I would just say to Ms. Kantner and Ms. Robinson, does any of that look familiar? Is that the type of things that they sent?

Ms. KANTNER. Yes. I had gotten the heating pad and the TENS unit and the gel cushion, which we brought over there, and then that is part of the mattress. What else did I say I had? Anyway, I have yet to receive a notice from Medicare that they paid any of this, but then when my Blue Shield and Blue Cross picked it up, they sent me a check for \$83.85 which they said I might owe the supplier.

For the inconvenience and aggravation that I have had with this equipment in my home, which I want it out of there immediately

and they never came for it, I am willing to give that check back or whatever.

According to this here it says that they billed Medicare \$535. The nonallowed amount was \$115.73, less Medicare payment of \$335.42, which I do not understand because I have never received anything from Medicare. With everything that we got it said denied because my son-in-law and daughter both called Camp Hill and all and said do not pay for any of this equipment.

Mr. SCHULZE. Thank you, Ms. Kantner.

Ms. Robertson.

Ms. ROBERTSON. Yes. I would like to mention one thing. My doctor did sign a sheet here. I do not know what it was for, but I am certain it was for something very menial. He explained it to me. He thought if I felt I needed it he would sign for it.

They must do some fudging around because here they checked that I need a commode. Is the patient bed-confined? Yes. Is the patient room confined? Yes. Is the patient susceptible to some sort of ulcers? I do not know how to explain it. Yes. Are you supervising the use of pressure pad? Yes. Is the patient's condition such that an alternative would be bed or chair confinement? Yes. Is the patient confined to a floor without bathroom facilities? Yes. Well, obviously I am not.

Mr. SCHULZE. Do you laugh about that when you go to the tennis court?

Ms. ROBERTSON. No. No, I do not. This upsets me.

Mr. SCHULZE. I can understand. Thank you. Thank you, Mr. Chairman.

Chairman PICKLE. I would pursue that question. Your doctor, Dr. Miller, had approved the original certificate that caused this equipment to be delivered to you?

Ms. ROBERTSON. Well, not all that equipment, but he did sign for something.

Chairman PICKLE. He signed the certificate of medical need—

Ms. ROBERTSON. Yes.

Chairman PICKLE [continuing]. For the equipment, whatever it was?

Ms. ROBERTSON. Yes.

Chairman PICKLE. It would not have been sent unless he had signed it?

Ms. ROBERTSON. But he did not sign for all the things that were sent to me, I am certain.

Chairman PICKLE. Whether he signed for all of it, the fact is he did sign.

Ms. ROBERTSON. He signed something.

Chairman PICKLE. Based on that, they sent you various equipment?

Ms. ROBERTSON. Yes.

Chairman PICKLE. Yet, when you called and said all this equipment came he said you do not need it?

Ms. ROBERTSON. I did not call him. I waited until my routine appointment, and then I asked him if he had had other patients complain about this sort of thing. He did. He had no idea that I had all this stuff.

Chairman PICKLE. Then it appears to me that your physician signed the original certificate almost as a matter of course.

Ms. ROBERTSON. Right. As Dr. Bell mentioned, he receives many requests. They think well, if the patient feels they need a knee brace or something we will let her have it.

Chairman PICKLE. Did he call you originally and say do you want this?

Ms. ROBERTSON. No.

Chairman PICKLE. Did any of your family call him and tell him that you wanted to?

Ms. ROBERTSON. Oh, no.

Chairman PICKLE. Did he check with anybody?

Ms. ROBERTSON. No.

Chairman PICKLE. He just approved it?

Ms. ROBERTSON. Yes.

Chairman PICKLE. Is this typical, in your opinion, of all the physicians?

Ms. ROBERTSON. Yes, I am assuming from what Dr. Bell indicated.

Chairman PICKLE. Dr. Bell has indicated that when you receive something through the mail that says Medicare on it, you sign it. I would make the point that it would appear to me that physicians as a whole are busy, and they do not have time to look at a lot of extra things. If they think somebody wants it it does not cost anything, so they will just check it off just almost as a matter of form and a matter of course.

Now, I say to you, Dr. Bell, that that to me comes near approaching negligence on the part of the physician. That is a matter of judgment by any individual, but the key to this whole problem is that certificate that must be signed by some physician.

Dr. BELL. I cannot agree with you more. The only thing I will say in terms of when you want to talk about negligence, it took me forever to get Medicare interested in this. I called. We could not find anyone that we could complain to. I am not sure the thing is who it is you want to blame.

I think that at this point it would really be wonderful if there would be a way that a physician such as Dr. Miller or myself could pick up the phone and call and say hey, we got this request that is clearly fraudulent. Will you do something about it? Will you investigate?

I want you to know, Mr. Chairman, that that was not and is still not available. If I were to be confronted with this today and did not know that this was taking place, I would not know where to go. I would call the same person, and a week later he would call me back. He would say write a letter. We would go back and forth.

You are right. It is certainly negligence on the part of the physicians. It is negligence all the way around.

Chairman PICKLE. Dr. Bell, I am not questioning your motives at all because I can understand how it happened, but it seems to me like it is almost a backup apology on the part of a physician when he legitimizes the thief and then calls the police to go get that thief.

I think that happens because the heat is on, and they are embarrassed that they have done this. There is no problem to this be-

cause they just authorize it. It is not going to cost them anything, and it might help Aunt Mamie to get some equipment.

I think that it is something that approaches negligence, and it has to be stopped.

Dr. BELL. I agree.

Chairman PICKLE. Maybe it would be helpful if we had someplace for them to call.

Dr. BELL. I agree with you, except that in both of these cases the heat was not on. Dr. Miller, myself and others may have looked for a place to try to rectify this. Up until now there was or is no place to do that.

Chairman PICKLE. Thank you. The Chair would yield to Mr. Jenkins from Georgia to make inquiries.

Mr. Jenkins.

Mr. JENKINS. Thank you, Mr. Chairman. Mr. Levin, your activities interest me. How were you recruited for this sales position?

Mr. LEVIN. I applied for a job as a driver.

Mr. JENKINS. As a driver?

Mr. LEVIN. Yes.

Mr. JENKINS. You were on a straight salary or a commission?

Mr. LEVIN. Hourly rate.

Mr. JENKINS. No commission involved?

Mr. LEVIN. No.

Mr. JENKINS. Did you have experience previously in the sales field?

Mr. LEVIN. Yes.

Mr. JENKINS. In medical equipment?

Mr. LEVIN. No.

Mr. JENKINS. So you had no experience whatsoever in this type of sales activity?

Mr. LEVIN. No, sir, not in the selling of these products.

Mr. JENKINS. Had you ever been in high promotion-type sales activity?

Mr. LEVIN. I have been in sales for about 30 years of my life, sir.

Mr. JENKINS. Generally in what areas?

Mr. LEVIN. Tangible, intangible.

Mr. JENKINS. Stocks? Bonds?

Mr. LEVIN. No, no, no.

Mr. JENKINS. Real estate? What type?

Mr. LEVIN. The furniture industry, franchise industry. I have done a number of things in selling. That is my field.

Mr. JENKINS. I am not quite sure that I understand. Did you just apply for a job as a driver? With all that sales experience it would appear to me that you would do more than deliver.

Mr. LEVIN. If you can help me get a job, Mr. Jenkins, I would certainly appreciate it. The conversation in essence was that while the ad itself was just a small worded ad regarding delivery of medical equipment and so on, the conversation that ensued was that he needed someone to handle his sales.

His son had been with him for years and had recently left him to set up his own DME company. He needed someone who had some background in doing just that—running a boiler room operation, running the sales, et cetera. This gentleman was not too well. He is ill, so he needed some help.

I was more or less learning the business from the bottom up. A good way is just to get out there and get involved in it.

Mr. JENKINS. So you were really hired to take over the boiler room sales operation?

Mr. LEVIN. No. He has a gal over there. They usually have a gal in charge of that. I would ultimately overlook all of it, yes.

Mr. JENKINS. It appears to me from your statement that you were knowledgeable in the field, yet you only worked for him for 6 weeks. I thought maybe that you were aware of this type of business or had some other knowledge about durable medical equipment.

Mr. LEVIN. No, sir. I am a fairly quick learner, and sales are sales. When you get ahold of the product and you are able to verbalize, et cetera, it is not a tough job to do. The job itself is not difficult. It really is not. There is a lot to be said about what goes on out there, but it is not difficult.

Mr. JENKINS. And once you got into this job, did you quit the operation because you thought it was fraudulent?

Mr. LEVIN. No. There was not really enough time for that. I was with them a very short time. I, together with some other people, were terminated because—the reason given—Medicare was not paying its bills. The owner was digging into his own personal funds to maintain his business.

Mr. JENKINS. Do you mean he was not making any money at the prices he was charging for this equipment?

Mr. LEVIN. Well, now you are getting into a field that I am not privy to. I do not know about that.

I am only saying that it seemed that Medicare was very slow—4 or 5 or 6 months—in paying the submitted bills. He, as a business owner, found it necessary to cut his staff back because he had to get into his own personal funds to maintain his business.

Mr. JENKINS. So your employment was terminated?

Mr. LEVIN. Yes.

Mr. JENKINS. You were released or fired or whatever?

Mr. LEVIN. Yes.

Mr. JENKINS. Along with several other people?

Mr. LEVIN. About six or seven others, yes.

Mr. JENKINS. You made no determination then during the 6 weeks that you worked there delivering this equipment that there was anything fraudulent involved?

Mr. LEVIN. Well, I would not say that I did not. I do not know if that is the proper terminology. The reason for my contacting the IG office is because in the period of time that I was there I, too, found what was going on as slightly reprehensible. It was obvious that a lot of these things that were being done were a total rip-off.

I should not use that word total. That is not totally true. It amazed me the number of our senior citizens that were not aware of the fact that they could indeed be eligible for needed medical equipment, whether it be a commode or a cane. They just had no knowledge. I ran into that a number of times. I do not know why it was so, but it was.

Mr. JENKINS. I was a little bit intrigued by your statement when you said that lying was a part of your business.

Mr. LEVIN. What I am saying is that I found myself doing that by saying things about medical equipment that I really was not qualified to say. I am only saying things I read. I was no authority.

Mr. JENKINS. When you lied you were told to, were you not, by somebody?

Mr. LEVIN. Oh, yes.

Mr. JENKINS. By whom?

Mr. LEVIN. By the owner of the business.

Mr. JENKINS. And who was that?

Mr. LEVIN. Well, I would prefer not to mention names, Mr. Jenkins, if you do not mind.

Mr. JENKINS. If you were told to lie to beneficiaries, I would like to know who told you to do that.

Mr. LEVIN. Again, I just do not feel that it really serves any particular purpose. The name has already been mentioned in your testimony. You do have it. I just do not feel that I want to mention the name.

Mr. JENKINS. Was it someone connected then with Allstate, I assume?

Mr. LEVIN. Yes.

Mr. JENKINS. Was that a large company or a small company?

Mr. LEVIN. I do not know how you would measure that. I do not really have that much knowledge of the business.

Mr. JENKINS. How many employees? Do you know?

Mr. LEVIN. Yes. He had approximately a dozen girls in the telemarketing division, and he had about four gals on his office staff. It is computerized and so on.

Mr. JENKINS. Is that company still in existence?

Mr. LEVIN. It is to the best of my knowledge. I do not know that it is. I really said that too quickly. I do not know that it is not.

Mr. JENKINS. Is it being operated by the same people?

Mr. LEVIN. I say again, if it is it is being operated by the same people, to the best of my knowledge.

Mr. JENKINS. You say you were paid. What was your salary?

Mr. LEVIN. \$7 an hour.

Mr. JENKINS. \$7 an hour?

Mr. LEVIN. Yes.

Mr. JENKINS. You were not given pay or promised any bonus or any commission?

Mr. LEVIN. I was, yes, but he reneged on that.

Mr. JENKINS. What type of a bonus?

Mr. LEVIN. The dollar amounts were never mentioned, but the intent was that when I am visiting one of the clients that my job is to get them to take additional medical equipment for their needs. Add-ons is the terminology they use, it seems, in the industry. I would do just that.

Of course, when the girl has originally spoken to the client and discussed her condition, whatever it may be, her job is to say that these are the things you are entitled to for the ailments that you have. She may list on the sheet of that new customer four, five or six items that apply.

I believe, according to Medicare rules, you can only deliver two at a time. That is put on the chart. Now, when we go out there and deliver the first two, let us say, we then review with the patient

what additional items she is entitled to. When she agrees to accept them I put that on the chart and turn that in when I return.

Mr. JENKINS. I think I understand the operation. Basically what you were to do is advise beneficiaries that they could get this equipment for nothing?

Mr. LEVIN. Part of it, sure.

Mr. JENKINS. And talk them into wanting a heating pad or a wheelchair or whatever it may be?

Mr. LEVIN. Sure.

Mr. JENKINS. Then you would get from your company a commission or a bonus?

Mr. LEVIN. Well, I would not. I was supposed to, but I—

Mr. JENKINS. You never did?

Mr. LEVIN. No, I did not.

Mr. JENKINS. The girls do?

Mr. LEVIN. The girls are waiting for the driver to come back to see what additional add-ons have been approved by her or him. That is a bonus to them. They get x number of dollars for each item.

Mr. JENKINS. But you talked them into it. Surely you would get a bonus or something besides the \$7 an hour, would you not?

Mr. LEVIN. I was a little disappointed myself.

Mr. JENKINS. You did not take the job just for \$7 an hour, did you? You were looking for the bonus because you had all this sales experience?

Mr. LEVIN. That really was not important to me.

Mr. JENKINS. The money was not?

Mr. LEVIN. No, I am talking about that job specifically. I was learning about the medical equipment in order to be effective in the sales of same and so on. That was a way of learning it.

Mr. JENKINS. They never paid you for these add-ons that you sold?

Mr. LEVIN. No.

Mr. JENKINS. Was that part of the problem with your leaving?

Mr. LEVIN. No.

Mr. JENKINS. It was not?

Mr. LEVIN. No. It had nothing to do with it. The only reason that I was terminated, as I said, was because he no longer could afford the amount of employees he had. That was the given reason.

Mr. JENKINS. I know our time is short and I am about through, so I cannot pursue this too long, but I want to ask you one other question to help me understand this. It is very difficult for me to fathom all of what is going on.

In some way the doctor has to acquiesce once you provide the add-ons. Did you explain to the beneficiary that she would have to get the physician to sign a form?

Mr. LEVIN. No.

Mr. JENKINS. Was that your job?

Mr. LEVIN. No. The way that goes down is simply this. When the girls make calls they contact two types of people. The first one is the typical housewife or widow who is home and can speak for herself and has a family doctor. She is told that this form is going to be sent to her doctor. Now, how can they send it to her doctor? They must get the doctor's name and address, some of which they

get from the person they are speaking to. They fill out this form. They now have the name and address, et cetera.

The other type of person they speak to would be the person who is possibly too poor to have a family doctor. They go to medical clinics. This should be brought to your attention, because that is where a lot of this is approved. A lot of these forms are sent to medical clinics, city clinics, et cetera. Who signs them I do not know, but they are signed by somebody in the hundreds. God knows how many.

Mr. JENKINS. And you have seen this in this operation? You have learned that from the ladies that were making the calls?

Mr. LEVIN. Yes, sir. Sure. I am there. I hear it. The girls always come to us when we return to see if they earned any additional money. If you get those add-ons then they make bonuses. That means they are now going to write them up. The girls are supposed to call the patient back to verify it. Sometimes they do. Sometimes they do not.

Mr. JENKINS. Mr. Levin, having had an opportunity to watch this operation and having been in sales for many years, from what you are describing to me it appears that there is no question but that there was a general scheme to defraud either Medicare or Blue Cross by this type of activity. Do you agree?

Mr. LEVIN. Oh, I think it goes without saying. I am even more surprised at the fact of how it is possible for anybody to approve such payments of costs. I do not know who is running the ship.

I agree with Mr. Chairman, Mr. Pickle, that this certainly, and it may be over-simplifying, but if you control the doctor's signatures you stop the problem. You absolutely stop the problem. They do mail them out, and someone signs it for the doctors. They do not see all that stuff. Mr. Pickle is perfectly correct.

Mr. JENKINS. I looked at one of these forms, and I did not see the \$700 cost of one of these things. Do you think it would be helpful to a physician if he knew that one of these mattresses was going to cost \$700? Do you think that might ring a bell?

Mr. LEVIN. It is certainly safe to say that it would not ring a bell. He does not care about that. He does not know about that. He does know that he has a patient, and he does know that the patient's name is thrust in front of him and whoever, it is either his first nurse or the receptionist or whomever, will sign these forms and back they come.

Let me tell you, they come back quick. In this particular company they hire a girl who sits there until 9 at night typing up what the girls have sold that day. There is a mess of mail that goes out with return envelopes, self-addressed, stamped, et cetera. It comes back within 2 weeks.

The only time a doctor reneges, and he does, is indeed when——

Chairman PICKLE. He is called.

Mr. LEVIN. Yes, he is called. He is called by the patients themselves.

I give you a case in point. I went to a house, a very, very lovely home with a couple of Cadillacs outside. It was a very affluent family. I had a couple of items to deliver for this gentleman, her husband. She answered the door. She was surprised to see me.

She said I told the girl that I did not want any of these things. My first response then was to show her the signed slip by the doctor that it was authorized. She was a very astute woman. We had a very nice conversation because the items that I had, I think as I recall, was a back support and knee braces for this gentleman.

She said you know, my husband has Alzheimer's disease. I went over there and said hello to the guy. He really looked terrific. Then she showed me a portrait that was on the wall, a huge picture that had been enlarged. Only 3 weeks ago they had just come back from a camping trip. The picture was of him rowing a rowboat.

She said do you really think my husband needs these things? I said no, of course I do not. I would not even leave them. She said wait a minute. Do not go away. She picked up the phone and called the doctor. The doctor denied signing it. I said, what is the doctor's name? There was his name on the slip.

Now, the doctor will say that he did not sign it because it is his patient. He does not want to lose his patient. There is a definite situation of greed, but it is a normal thing in my judgment, so that is what he does.

Any time someone does call, and not many of them do—I do not believe many of them do—invariably the doctor will say I did not sign any such thing; that is not true.

Mr. JENKINS. Mr. Levin, are you in sales now?

Mr. LEVIN. I am looking for a job, Mr. Jenkins.

Mr. JENKINS. For a driver you are a fast learner.

Mr. LEVIN. Thank you, sir.

Mr. JENKINS. Thank you.

Chairman PICKLE. Mr. Levin, when you call on an individual or go to a nursing home do you have the Social Security number of that individual?

Mr. LEVIN. That is already on the form. They have their Medicare number. Yes, sir.

Chairman PICKLE. Do you call on other people to sell equipment or only people in Medicare?

Mr. LEVIN. Only items that have been signed by a doctor and are Medicare patients, yes.

Chairman PICKLE. So you do not call the public? You go only where there is a Social Security number that has been established?

Mr. LEVIN. Absolutely.

Chairman PICKLE. Therefore, you can bill Medicare?

Mr. LEVIN. Absolutely.

Chairman PICKLE. From a personal standpoint, you were terminated because Medicare was slow?

Mr. LEVIN. That is at least what he said.

Chairman PICKLE. That is what he said. To the contrary, normally Medicare is much faster than Blue Cross or Blue Shield. At any rate, you say that they were slow.

Now, if you had not been terminated you probably would have kept on working for this company hoping you would make a bonus. I assume that would be normal?

Mr. LEVIN. Yes.

Chairman PICKLE. It bothers me that in your case you probably would have continued on if you had not been terminated, even though you said that it bothered you that you did not like to be

called a medical technician and you did not know whether they really needed the equipment, as you stated this morning.

I think you would be typical of thousands upon thousands of people who are selling this kind of equipment. Somehow I think we have to try to consider some way of examining how we might control or limit the salesmen themselves. That is another matter and probably not directed to this point.

The Chair wants to recognize Mr. Gekas, who has joined our committee here this morning. We are glad to have you. Mr. Gekas?

Mr. GEKAS. Thank you. I am very grateful to the committee, because it seems that the members here have focused in on the exact problems that exist in this field. I have learned a great deal from this.

The gentleman from Texas, the gentleman from Georgia and Dick Schulze here have asked the questions that pinpoint the two areas, the doctor's certificate and the standard of charges that are made by the suppliers.

In our preliminary inquiry, I must say to the committee before I want to ask one question of Mr. Levin that most of the suppliers in our commonwealth here and outside the commonwealth are bona fide, proper suppliers, but somehow that range of charges for what might be good equipment is sometimes abused by fast-working, hustling groups that put on the market a shoddier piece of equipment and then go into profiteering, gouging, and so forth. You hit on the questions that are going to be cogent in this area.

What I would like to ask Mr. Levin if he knows, and he may not, is whether he knew whether his company, the company that he worked for that is in the testimony, had a standard group of charges that they knew were comparable to other companies who were providing these same kinds of supplies.

In other words, what I am trying to get at is, pursuing the questions that were asked by the members of the committee, if indeed there was a 200 percent or 300 percent, as Ms. Gilmore was able to show, profit in these things pursuant to charges that were authorized by the general market standards that Blue Shield and Blue Cross would adopt, did you have any knowledge of comparable companies and their prices for similar kinds of equipment?

Mr. LEVIN. I heard her explain how they come to the decision—how Medicare comes to the decision—about what the providers are entitled to. It sort of surprised me a little bit. Maybe that was the bottom line.

It is my understanding that Medicare sets the price structure for any item, any DME item, and that indeed it can vary from State to State or area to area, however they control it.

Mr. GEKAS. We understand that, but I am asking whether you have any knowledge that this company for which you worked was using prices that were wildly inconsistent with other suppliers or were they within ranges that—

Mr. LEVIN. I do not have that knowledge, sir.

Mr. GEKAS. That is all I wanted to ask to see if you knew that. I have no further questions. I appreciate the ability to ask questions.

Chairman PICKLE. Thank you, Mr. Gekas. We are pleased that you can be with us today.

The Chair is going to announce that we will go to the next panel. I thank each of you for testifying. What you have said this morning has been very helpful to the committee. This information will be compiled and will be disseminated to other Members of Congress to see if we cannot find a way to do this more efficiently and more effectively.

I am going to be interested in talking to the next panel about what is going to happen right here in this area about cases that are pending, but I do thank each one of you for coming. Thank you.

Ms. ROBERTSON. Mr. Pickle, could I make one comment?

Chairman PICKLE. Yes.

Ms. ROBERTSON. I think we should eliminate telephone soliciting, radio and television ads and so forth appealing to Medicare patients. I think it all should be in the hands of the doctors to request equipment for their patients. It was mentioned there are people who go to clinics. They are seeing doctors, nurses or whatever. I think they should be making these requests. We are just opening up the gates for all kinds of fraud.

Mr. JENKINS. Ms. Robertson, I think your suggestions are well taken. I wanted to question Dr. Bell and he had to leave, but if he is receiving 20 unsolicited requests weekly and that pattern is duplicated across the country, then I think we must get back to letting the physician make the recommendation, as you are suggesting, so that he or she has the direct responsibility.

I know there are some problems with trying to curtail advertising and that type of thing under the Constitution, but I thank you for your suggestion.

Chairman PICKLE. And I do, too. Thank you very much for that comment. Thank you again.

I am going to call to the witness table Larry Morey and Jack Hartwig, representing the Department of Health and Human Services. Representing then the Department of Justice will be Michael Baylson and James Sheehan. If you four gentlemen will take your places.

Larry Morey is Deputy Inspector General for Investigations of the Health and Human Services, and Jack Hartwig is the Regional Inspector General for Investigations. He is accompanied by Pat Gilmore, who has already presented some of this equipment.

Continuing, representing the Department of Justice is Michael Baylson, who is the U.S. attorney, the Eastern District of Pennsylvania, accompanied by James G. Sheehan, the assistant U.S. attorney, Chief, Civil Division.

We are glad to have each one of you with us this morning. We will proceed first to hear from Larry Morey. Mr. Morey.

STATEMENT OF LARRY D. MOREY, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, INSPECTOR GENERAL'S OFFICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JACK HARTWIG, REGIONAL INSPECTOR GENERAL FOR INVESTIGATIONS, AND PAT GILMORE, INVESTIGATOR

Mr. MOREY. Mr. Chairman, it is a pleasure to be here. You have already introduced us. Let me just say it is a great opportunity for

us to report on the progress of our office in the health care fraud area.

My testimony will discuss fraudulent durable medical equipment, DME, supply practices and schemes. I will give you some examples of those schemes in the State of Pennsylvania.

I would like to make this brief and ask that my complete testimony be submitted for the record.

Chairman PICKLE. Your statement will be included.

Mr. MOREY. DME can play a critical part in the health care of an elderly or disabled person. Consequently, Medicare part B extends coverage for certain DME items including oxygen equipment, wheelchairs, home dialysis systems, seat lift mechanisms and other medically necessary equipment that physicians prescribe for home use. Medicare also pays the approved rental charges if the equipment is rented.

Now, DME suppliers submit claims along with a certificate of medical necessity prepared by a physician, as we have heard. However, even though this process sounds relatively straightforward, fraud and abuse in the DME industry continues to be a significant concern to the OIG and the Health Care Financing Administration.

As investigators of fraud and abuse in Federal health care programs, the OIG is seeing a nationwide increase of problems with DME suppliers. While DME fraud occurs throughout the United States, it varies in intensity depending upon the carrier and the elderly populations of the various States.

The problems in Pennsylvania, for example, are more acute as DME supplies have discovered that reimbursement by the Medicare carrier tends to be higher in Pennsylvania than in other States making this an attractive area for unscrupulous DME suppliers to operate.

We have identified six basic fraud schemes which seem to cover most of the fraud activity in the DME industry. Let me cover those schemes: carrier shopping, unbundling, overzealous marketing practices, abuse of certificates of medical necessity, misuse of provider number, and signature on file.

One of the most prevalent fraudulent practices used by dishonest DME companies is locality billing or carrier shopping. In general, carrier jurisdiction over claims payment is based on either the location of the DME business or where they say the point of sale of the supply or of the service.

Many disreputable companies have developed schemes which, coupled with modern telephone technology, make it appear that they are located in and make their sales from localities that pay a higher reimbursement rate. Common tactics employed include intricate networks or mail drops, telephone answering machines, call forwarding and other devices.

Another example is unbundling. Unbundling is a widespread practice among doctors, hospitals, and other health care providers. Claims for medical supplies are inflated far above their actual cost by billing for component parts.

Some DME companies employ intense, high pressure marketing techniques to coerce beneficiaries. That is what we have heard this morning.

Another scheme employed by DME companies usually is in the form of preparation of a false authorization or CMNs. These documents are needed to obtain Medicare reimbursement from the carrier and must be signed by a physician. The CMNs often list DME which the beneficiary has not requested and show false diagnoses.

Another example is the misuse of the provider number. The provider numbers are identifiers assigned to specific providers for billing purposes by a Medicare carrier. Unfortunately, anyone can get a provider number for DME billing purposes, or a provider can get more than one number and submit bills regardless of whether they are qualified to do so.

The last scheme I would like to address is the signature on file. Our investigations have revealed that there are carriers that have inappropriately issued instructions which indicate that suppliers are permitted to obtain and retain in a file a single lifetime authorization from the beneficiary. Once this lifetime authorization has been obtained, DME suppliers frequently submit claims for items or services which are not included under the original authorization.

Overall, our review, as well as our cases, have found that DME suppliers were directly marketing equipment to beneficiaries to induce a demand for these services. The amount of direct, as well as subtle, pressure being placed on some physicians either directly by the DME supplier or by unknowing beneficiaries force us to look for new ways to prevent this fraud.

Increasingly we are finding Medicare DME expenditures for items that are of little value to the beneficiary or not requested by the beneficiary or ordered by the physician.

Mr. Hartwig and I are available to answer any of your questions, Mr. Chairman.

[The prepared statement follows:]

**TESTIMONY OF LARRY D. MOREY
DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS
OFFICE OF THE INSPECTOR GENERAL
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

GOOD MORNING. I AM LARRY MOREY, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS WITH THE OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES. I AM ACCOMPANIED TODAY BY JACK HARTWIG, REGIONAL INSPECTOR GENERAL FOR INVESTIGATIONS OF OUR PHILADELPHIA FIELD OFFICE. WE ARE PLEASED TO HAVE THE OPPORTUNITY TO REPORT ON OUR OFFICE'S PROGRESS IN INVESTIGATING MEDICARE FRAUD, PARTICULARLY DURABLE MEDICAL EQUIPMENT (DME) FRAUD. BECAUSE THERE ARE SEVERAL CASES PENDING IN FEDERAL COURT INVOLVING DME COMPANIES, I HAVE LIMITED MY TESTIMONY TO THOSE FACTS WHICH ARE NOT UNDER THE PROTECTION OF FEDERAL GRAND JURIES.

BACKGROUND

MEDICARE, AUTHORIZED BY TITLE XVIII OF THE SOCIAL SECURITY ACT, HELPS PAY MEDICAL COSTS FOR ABOUT 35 MILLION AGED AND DISABLED PEOPLE. MEDICARE PROVIDES TWO FORMS OF PROTECTION. PART A - HOSPITAL INSURANCE - COVERS INPATIENT HOSPITAL SERVICES, HOME HEALTH SERVICES, AND VARIOUS OTHER INSTITUTIONAL SERVICES. PART B - SUPPLEMENTARY MEDICAL INSURANCE - COVERS PHYSICIAN, OUTPATIENT HOSPITAL, AND OTHER HEALTH SERVICES, SUCH AS DIAGNOSTIC TESTS. IN FY 1990, EXPENDITURES FOR PART B TOTALLED \$43 BILLION - DME PAYMENTS WERE APPROXIMATELY \$3 BILLION.

MEDICARE PART B INCLUDES PAYMENT FOR DME ITEMS SUCH AS OXYGEN EQUIPMENT, WHEELCHAIRS, AND OTHER MEDICALLY NECESSARY EQUIPMENT THAT PHYSICIANS PRESCRIBE FOR HOME USE. MEDICARE ALSO PAYS THE APPROVED RENTAL CHARGES IF THE EQUIPMENT IS RENTED. DME SUPPLIERS SUBMIT CLAIMS ALONG WITH AUTHORIZATION DOCUMENTS KNOWN AS CERTIFICATES OF MEDICAL NECESSITY (CMNs) PREPARED BY A PHYSICIAN. TO PROCESS MEDICARE PART A AND B CLAIMS, HCFA USES CONTRACTORS KNOWN AS FISCAL INTERMEDIARIES AND CARRIERS, RESPECTIVELY. FRAUD IN THE DME INDUSTRY CONTINUES TO BE A SIGNIFICANT CONCERN TO THE OIG. WE ARE FINDING THAT UNSCRUPULOUS SUPPLIERS ARE EMPLOYING A VARIETY OF QUESTIONABLE MARKETING TECHNIQUES, AS WELL AS SUBMITTING INFLATED BILLINGS AND MANIPULATING LOOPHOLES IN THE LAW. IN THE PHILADELPHIA REGION, WE ARE CURRENTLY INQUIRING INTO ABOUT 25 INSTANCES IN WHICH DME SUPPLIERS MAY HAVE COMMITTED MEDICARE FRAUD.

WE ARE INCLUDING THE FOLLOWING CHART TO ILLUSTRATE SOME OF THE OVERCHARGING INCURRED BY MEDICARE FOR DME EQUIPMENT. THESE FIGURES WERE OBTAINED FROM PENNSYLVANIA BLUE SHIELD (PBS) DURING THE COURSE OF OUR INVESTIGATIONS.

<u>ITEM</u>	<u>SUPPLIER'S COST</u>	<u>BILLED TO MEDICARE</u>	<u>MEDICARE PAID</u>
COMMODE CHAIR	\$ 28.00	\$195.00	\$ 94.50
DECUBITUS PAD	40.00	700.00	434.95
WHEELCHAIR CUSHION	8.00	385.00	248.96
MOIST HEATING PAD	7.97	75.00	53.03
HOSPITAL BED	647.00	3,100.00	1,632.70
KNEE BRACE	23.83	125.00	39.17
TENS	49.90	750.00	452.00
SEAT LIFT CHAIR	280.00	949.00	881.00

OIG ACTIVITIES

OVER THE YEARS, THE OIG HAS CONDUCTED ANALYSES, ISSUED FRAUD ALERTS, AND UNDERTAKEN CRIMINAL INVESTIGATIONS INVOLVING DME. IN ADDITION, WE HAVE PRESENTED TESTIMONY TO CONGRESS AND MADE RECOMMENDATIONS FOR LEGISLATIVE SOLUTIONS. I WOULD LIKE TO MAKE COPIES OF OUR PREVIOUS REPORTS AVAILABLE FOR THE RECORD. IN ADDITION TO THE ISSUANCE OF REPORTS ON DME, WE DEVELOPED A NOTICE, WITH THE ASSISTANCE OF HCFA, ALERTING MEDICARE BENEFICIARIES IN CERTAIN STATES TO THE PRACTICES OF FRAUDULENT DME COMPANIES. THE NOTICE INFORMS BENEFICIARIES ON HOW TO AVOID THE PURCHASE OF UNNECESSARY AND UNWANTED DME SERVICES, SUPPLIES, AND EQUIPMENT. THROUGH EDUCATION, WE HOPE TO REDUCE DME FRAUD.

WE HAVE SENT SEVERAL INTERNAL DOCUMENTS TO HCFA CARRIERS AND INTERMEDIARIES CONCERNING DME ISSUES. FOR EXAMPLE, WE ISSUED AN INTERNAL FRAUD ALERT TO OUR FIELD OFFICES BASED ON AN INVESTIGATION IN FLORIDA. OUR INVESTIGATION REVEALED THAT A SUPPLIER OF FOOT SPLINTS AND SUPPLIES, KNOWN AS ORTHOTICS, OBTAINED MEDICARE PAYMENTS FOR DME THAT WAS IMPROPERLY AUTHORIZED BY THE PATIENT'S PHYSICIAN AND WAS NOT PROVIDED AS CLAIMED. CARRIERS HAVE BEEN ALERTED TO THIS TYPE OF ACTIVITY, AND HAVE BEEN ENCOURAGED TO DETERMINE WHETHER PROPER PHYSICIAN AUTHORIZATIONS HAVE BEEN OBTAINED BEFORE DEVICES ARE PROVIDED TO PATIENTS.

OUR STAFF HAS ALSO WORKED WITH HCFA TO ESTABLISH A STANDARD CMN TO BE USED BY

THE ATTENDING PHYSICIAN TO DOCUMENT THE NEED FOR OXYGEN IN THE HOME. A NEW STATEMENT HAS BEEN ADDED WHICH REQUIRES THE PHYSICIAN TO CERTIFY THAT THE INFORMATION IS TRUE, ACCURATE AND COMPLETE.

OBRA '90 DME PROVISIONS

THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990 (OBRA '90) MAKES SEVERAL STATUTORY CHANGES IN THE AREA OF DME. MANY CHANGES WERE BROUGHT ABOUT AFTER DEFICIENCIES IN DME REIMBURSEMENT HAD BEEN BROUGHT TO LIGHT BY OUR OFFICE AND HCFA.

WHILE THE CHANGES MANDATED BY OBRA '90 WILL REDUCE ABUSIVE DME PRACTICES AND EXCESSIVE DME COSTS, OTHER ABUSES WILL CONTINUE. NATIONAL PAYMENT LIMITS AND FLOORS WILL NOT ELIMINATE GEOGRAPHIC VARIATIONS, AND THEY DO NOT APPLY TO ALL CATEGORIES OF DME.

INVESTIGATIONS OF HEALTH CARE FRAUD

WE HAVE IDENTIFIED SEVERAL SCHEMES INDICATIVE OF THE FRAUDULENT ACTIVITIES IN THE DME INDUSTRY. THEY INVOLVE:

- o OVERZEALOUS MARKETING;
- o CERTIFICATES OF MEDICAL NECESSITY;
- o CARRIER SHOPPING;
- o UNBUNDLING;
- o SIGNATURE ON FILE; AND,
- o MEDICARE CARRIER PROVIDER NUMBERS

1. OVERZEALOUS MARKETING

SOME DME COMPANIES EMPLOY HIGH PRESSURE MARKETING PRACTICES TO COERCE BENEFICIARIES INTO ORDERING UNNEEDED EQUIPMENT. THROUGH ADVERTISEMENTS, BENEFICIARIES ARE TOLD THAT CERTAIN EQUIPMENT CAN BE SUPPLIED IN THEIR HOMES AT NO CHARGE TO THEM. ONE AGGRESSIVE TECHNIQUE IS TELEMARKETING. BENEFICIARIES ARE CONTACTED BY TELEPHONE BY HIGH PRESSURE SALESMEN WHO TAKE ADVANTAGE OF ELDERLY BENEFICIARIES WITH CONFUSING SALES PITCHES. MANY OF THESE MARKETING TECHNIQUES IMPLY THAT BENEFICIARIES HAVE A RIGHT TO EQUIPMENT, EVEN IF THEY DO NOT MEET THE MEDICAL CRITERIA. ONCE THE COMPANIES OBTAIN THE NAME OF THE BENEFICIARY'S PRIMARY PHYSICIAN, THEY PRESSURE THE PHYSICIAN TO APPROVE EQUIPMENT PURCHASES FOR THEIR PATIENTS BY IMPLYING THAT FAILURE TO AUTHORIZE THE EQUIPMENT COULD RESULT IN PATIENTS SEEKING OTHER PHYSICIANS.

WE HAVE AN INCREASING NUMBER OF CASES THAT DIRECTLY TARGET NURSING HOME PATIENTS. IN THESE CASES, MARKETING PRACTICES ARE USED BY DME SUPPLIERS TO OBTAIN ACCESS TO NURSING HOME PATIENTS AND THEIR MEDICARE RECORDS. ADDITIONALLY, THE NURSING HOMES ARE APPROACHED BY BILLING AGENTS WHO OFFER 'INNOVATIVE' BILLING TECHNIQUES -- SUCH AS BILLING MEDICARE PART B FOR EQUIPMENT PREVIOUSLY PAID FOR BY MEDICARE PART A, OR BY BILLING FOR ITEMS AND SERVICES WHICH WERE NEVER SUPPLIED. MOST OF THESE CASES ARE IN THE EARLY STAGES OF DEVELOPMENT. LET ME GIVE YOU AN EXAMPLE.

- o WE ARE CURRENTLY INVESTIGATING A BILLING SERVICE IN CONNECTION WITH BILLINGS PREPARED AND SUBMITTED ON BEHALF OF A NURSING HOME. THIS BILLING SERVICE WAS UNDER CONTRACT TO ANALYZE MEDICAL RECORDS AND BILLINGS CORRESPONDING TO SERVICES PERFORMED, DETERMINE WHICH SERVICES WERE EITHER NOT BILLED OR BILLED INCORRECTLY, AND SUBMIT CLAIMS FOR THESE SERVICES. IN THIS CASE, THE NURSING HOME BROUGHT THIS CASE TO OUR ATTENTION. AN INTERNAL AUDIT CONDUCTED BY THE NURSING HOME AFTER THE FACT IDENTIFIED A SUBSTANTIAL AMOUNT OF FRAUDULENT BILLINGS BY THE BILLING AGENT.

WE WOULD NOTE THAT ONE MECHANISM USED TO SELL SUPERFLUOUS AND EXORBITANTLY PRICED DME IS TO WAIVE -- IN OTHER WORDS, NOT BILL FOR -- COPAYMENTS AND DEDUCTIBLES UNDER MEDICARE PART B. A PROVIDER, PRACTITIONER, OR SUPPLIER WHO ROUTINELY WAIVES MEDICARE COPAYMENTS OR DEDUCTIBLES IS MISSTATING THE ACTUAL CHARGE OF AN ITEM OR SERVICE -- THIS MAY REPRESENT A FALSE CLAIM TO THE GOVERNMENT.

AT FIRST GLANCE, IT APPEARS THAT ROUTINE WAIVER OF COINSURANCE AND DEDUCTIBLES HELPS MEDICARE BENEFICIARIES. THE DME SUPPLIER MAY CLAIM THAT THE BENEFICIARY INCURS NO COSTS. THIS IS NOT TRUE. STUDIES HAVE SHOWN THAT IF PATIENTS ARE REQUIRED TO PAY EVEN A SMALL PORTION FOR THEIR CARE, THEY WILL MAKE MORE APPROPRIATE UTILIZATION DECISIONS BY SELECTING ITEMS OR SERVICES BECAUSE THEY ARE MEDICALLY NEEDED, RATHER THAN SIMPLY BECAUSE THEY ARE FREE. ULTIMATELY, IF MEDICARE

PAYS MORE FOR AN ITEM THAN IT SHOULD, OR IF IT PAYS FOR UNNECESSARY ITEMS, THERE ARE LESS MEDICARE FUNDS AVAILABLE TO PAY FOR TRULY NEEDED ITEMS.

TO HELP REDUCE FRAUD IN THIS AREA, WE ISSUED A SPECIAL FRAUD ALERT WARNING PROVIDERS, PRACTITIONERS, AND SUPPLIERS OF HEALTH CARE ITEMS AND SERVICES WHO ROUTINELY WAVE MEDICARE DEDUCTIBLE AND COPAYMENT CHARGES THAT THIS PRACTICE PLACES THEM AT RISK OF CRIMINAL PROSECUTION.

2. CERTIFICATES OF MEDICAL NECESSITY

AUTHORIZATION BY THE BENEFICIARY'S PHYSICIAN IS NEEDED TO RECEIVE REIMBURSEMENT FROM THE MEDICARE CARRIER. THIS IS ACCOMPLISHED THROUGH CMNs.

OUR INVESTIGATIONS HAVE REVEALED THAT SOME SUPPLIERS FALSIFY THE CMNs IN ORDER TO RECEIVE PAYMENT FOR EQUIPMENT. WE HAVE ALSO FOUND THAT MANY SUPPLIERS LIST DME ON CMNs WHICH THE BENEFICIARY HAS NOT REQUESTED. OFTEN, FORMS ARE COMPLETELY FILLED OUT BY THE DME SUPPLIER, REQUIRING ONLY A PHYSICIAN'S SIGNATURE. EVEN IF THE PATIENT'S PHYSICIAN OBJECTS TO A SUPPLIER'S REQUEST FOR APPROVAL, SOME SUPPLIERS WILL EITHER PAY A CO-CONSPIRATOR TO SIGN FALSE CMNs, OR FORGE THE ATTENDING PHYSICIAN'S SIGNATURE.

OBRA '90 PROHIBITS SUPPLIERS FROM PROVIDING PHYSICIANS OR BENEFICIARIES COMPLETED OR PARTIALLY COMPLETED CMNs AND REQUIRES PRIOR APPROVAL. HOWEVER, WE HAVE NOTICED SEVERAL DME SUPPLIERS SENDING CMNs TO PHYSICIANS WITH NOTES ATTACHED EXPLAINING HOW TO COMPLETE EACH BLOCK OF THE FORM, IN ORDER TO ENSURE MEDICARE WILL PAY FOR THE ITEMS BEING SOLD. FOR EXAMPLE,

- o RECENTLY, A PHILADELPHIA DME COMPANY, AGREED TO A \$462,000 CIVIL SETTLEMENT FOR FILING FALSE MEDICARE CLAIMS. THE COMPANY ALTERED CMNs AND BILLED FOR SERVICES NOT RENDERED.
- o WE HAVE ANOTHER INVESTIGATION INVOLVING A DME SUPPLIER IN PENNSYLVANIA. WE ARE LOOKING INTO ALLEGATIONS THAT THIS COMPANY PROVIDED MEDICALLY UNNECESSARY DME; THAT SOME ITEMS WERE BILLED FOR PAYMENT AND NOT RECEIVED BY THE PATIENT; AND THAT COMPANY SALESPERSONS FORGED PHYSICIAN'S SIGNATURES ON CMNs. WE CONDUCTED INTERVIEWS WITH BENEFICIARIES, AS WELL AS ADMINISTRATORS OF PERSONAL CARE HOMES AND SEVERAL PHYSICIANS, TO SUBSTANTIATE THE ALLEGATIONS. THE CASE HAS BEEN PRESENTED TO THE U.S. ATTORNEY'S OFFICE FOR PROSECUTION. WE ANTICIPATE INDICTMENTS SHORTLY.

INVESTIGATIONS INTO THE SEAT LIFT CHAIR INDUSTRY BROUGHT TO OUR ATTENTION THE FALSIFICATION OF CMNs. IN SOME INSTANCES, DOCTORS MERELY SIGNED STANDARDIZED APPROVAL FORMS FOR PATIENTS TO OBTAIN THE CHAIRS. IN OTHER INSTANCES, DOCTORS COMPLAINED TO OUR INVESTIGATORS THAT THE COMPANIES DELIVERED CHAIRS TO PATIENTS WHO WOULD NEVER HAVE THOUGHT OF OBTAINING THEM HAD IT NOT BEEN FOR THE WAY THE CHAIRS WERE MARKETING. THE CHAIRS WERE DELIVERED TO THEM BEFORE MEDICAL APPROVAL WAS GIVEN AND THEN REPOSSESSED, TO THE DISTRESS OF THE PATIENTS, WHEN MEDICAL NECESSITY APPROVALS WERE DENIED.

TO DISCOURAGE SOME OF THE MARKETING TECHNIQUES WE HAVE SEEN, WE RECOMMEND THAT THE PATIENT'S PHYSICIAN BE REQUIRED TO WRITE A PRESCRIPTION FOR DME EQUIPMENT. THIS CHANGE WOULD ELIMINATE TELEMARKETING OF USELESS AND UNNECESSARY EQUIPMENT.

TO IMPROVE ASSESSMENT OF THE MEDICAL NECESSITY OF DME EQUIPMENT, WE BELIEVE THAT INFORMATION PERTAINING TO THE PHYSICIAN'S ROLE IN THE BENEFICIARIES TREATMENT, THE PLAN OF TREATMENT, AND NEED FOR THE DME SHOULD BE INCLUDED IN THE CMN. ADDITIONALLY, THE PHYSICIAN SHOULD BE REQUIRED TO SIGN THE CMN WITHIN 45 DAYS OF THE LAST EXAM OR TREATMENT. THE REGULATIONS SHOULD ALSO REQUIRE THAT THE CMN INCLUDE A STATEMENT THAT WILLFUL AND INTENTIONAL MISREPRESENTATION OF FACT CONSTITUTES FRAUD AND MAY SUBJECT PROVIDERS TO CRIMINAL PROSECUTION, CIVIL MONETARY PENALTIES, OR EXCLUSION FROM THE MEDICARE AND MEDICAID PROGRAMS.

AS A PRECAUTION, THE MANUAL INSTRUCTIONS TO THE CARRIERS ISSUED BY HCFA SHOULD SPECIFICALLY REQUIRE CARRIERS TO REVIEW THE CMNs AND NOT PAY CLAIMS SUBMITTED WITH XEROXED COPIES OF CMNs.

3. CARRIER SHOPPING

IN THE PAST, DME REIMBURSEMENT RATES WERE BASED ON THE LESSER OF THE USUAL, CUSTOMARY, OR PREVAILING CHARGE, KNOWN AS A "REASONABLE" CHARGE. UNDER THIS

METHOD OF DETERMINING REIMBURSEMENT RATES. CARRIERS WERE WORKING UNDER BROAD GUIDELINES PROVIDED BY HCFA ON HOW TO PRICE DME SERVICES. WHEN PRICING DME, EACH CARRIER DECIDED WHAT INFORMATION WAS NEEDED FOR PRICING; HOW TO DEVELOP THE INFORMATION NEEDED; THE SOURCES OF INFORMATION TO BE USED; AND THE EXTENT OF DEVELOPMENT UNDERTAKEN. THESE DIFFERENT APPROACHES TO PRICING RESULTED IN CONSIDERABLE VARIANCE IN REIMBURSEMENT LEVELS FOR DME AMONG THE CARRIERS.

THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA '87) MANDATED THE ESTABLISHMENT OF FEE SCHEDULES. FIFTY-SEVEN SEPARATE FEE SCHEDULES -- ONE FOR EACH MEDICARE CARRIER AREA -- WERE CALCULATED USING "HISTORICAL REASONABLE" CHARGES. IN EFFECT, THIS LOCKED IN TO PLACE NUMEROUS VARIATIONS IN REIMBURSEMENT LEVELS FOR DME AMONG THE CARRIERS.

THESE VARIATIONS LED TO A WIDESPREAD PRACTICE KNOWN AS "CARRIER SHOPPING". UNDER THIS PRACTICE, SUPPLIERS OFTEN SHOP AROUND LEARNING AS MUCH AS THEY CAN ABOUT EACH CARRIER'S REIMBURSEMENT LEVELS AND COVERAGE POLICIES. THEY LEARN WHICH CARRIERS PAY THE MOST FOR DME IN AN EFFORT TO OBTAIN MAXIMUM REIMBURSEMENT FOR THEIR PRODUCTS. THEY ALSO LEARN JUST HOW MUCH DME EACH CARRIER WILL ALLOW BEFORE STOPPING OR CUTTING BACK ON PAYMENTS.

ARMED WITH THIS INFORMATION, SOME SUPPLIERS ESTABLISH MULTIPLE BUSINESS LOCATIONS AND BILL A HIGH REIMBURSER. THIS SUBVERTS MEDICARE GUIDELINES REGARDING "POINT OF SALE." UNDER THESE GUIDELINES, BILLS FOR DME SHOULD BE SUBMITTED TO THE MEDICARE CARRIER LOCATED WHERE THE COMPANY SELLING THE EQUIPMENT RECEIVES THE ORDER. LET ME GIVE YOU SOME EXAMPLES.

- o WE HAVE A CASE INVOLVING TWO DME SUPPLIERS IN PENNSYLVANIA WITH SUBSIDIARIES IN FLORIDA AND OTHER STATES. OUR INVESTIGATION REVEALED A SCAM THAT ALLEGEDLY HAS NETTED THESE TWO FIRMS MORE THAN \$4 MILLION FROM MEDICARE IN THE PAST TWO YEARS FOR MEDICAL EQUIPMENT. IN ADDITION, THE SUBSIDIARIES ARE ALLEGEDLY BILLING PENNSYLVANIA BLUE SHIELD TO OBTAIN MAXIMUM REIMBURSEMENT FOR THEIR PRODUCTS. THESE FIRMS ALLEGEDLY CONTACTED MEDICARE BENEFICIARIES, ALL SENIOR CITIZENS, BY TELEPHONE; OBTAINED THEIR SOCIAL SECURITY NUMBERS, MEDICAL HISTORIES AND PHYSICIAN'S NAMES; PREPARED FALSE CERTIFICATES ABOUT THEIR MEDICAL CONDITIONS; INDUCED PHYSICIANS TO SIGN THE FALSE DOCUMENTS; AND SHIPPED THE UNNEEDED AND UNWANTED MEDICAL EQUIPMENT TO BENEFICIARIES IN SOUTHERN NEW JERSEY, EASTERN PENNSYLVANIA AND OTHER AREAS.
- o WE ARE ALSO INVESTIGATING A FLORIDA BILLING SERVICE THAT MAY HAVE PREPARED BILLINGS FOR ABOUT 15 PENNSYLVANIA DME AND AMBULANCE COMPANIES. THESE COMPANIES ARE, IN TURN, USING THIS BILLING SERVICE TO OBTAIN BENEFICIARY INFORMATION FOR SOLICITATION PURPOSES. OTHER SCHEMES MAY BE IN PLACE.

OBRA '90 MODIFIES THIS PAYMENT METHODOLOGY BY ESTABLISHING NATIONAL DME REIMBURSEMENT LIMITS AND FLOORS TO BE PHASED IN OVER A PERIOD OF 3 YEARS, BEGINNING IN 1991. THE INTENT IS TO LIMIT VARIATIONS IN DME REIMBURSEMENT RATES. HOWEVER, IT WILL ALSO UNINTENTIONALLY LIFT REIMBURSEMENT LEVELS IN CARRIER AREAS WITH HISTORICALLY LOW RATES. IN ANY EVENT, PRICING INEQUITIES WILL NOT BE RESOLVED FOR AT LEAST 3 YEARS.

CARRIERS JUST BEGAN PROCESSING CLAIMS WITH A JUNE 1 DATE OF SERVICE UNDER THIS NEW METHODOLOGY. THE OIG IS PLANNING A REVIEW OF THE SOUNDNESS OF THIS METHODOLOGY. IN THE INTERIM, WE ARE RECOMMENDING THAT HCFA CHANGE THE GUIDELINES CONCERNING THE "POINT OF SALE". THIS CHANGE WOULD REQUIRE THAT PAYMENT FOR DME BE MADE BY THE CARRIER SERVICING THE AREA WHERE THE BENEFICIARY LIVES. THE PROCESSING OF CLAIMS BY THE BENEFICIARY'S LOCAL CARRIER WILL DETER CARRIER SHOPPING.

4. "UNBUNDLING"

UNBUNDLING IS A WIDESPREAD PRACTICE AMONG DOCTORS, HOSPITALS AND OTHER HEALTH CARE PROVIDERS. CLAIMS FOR MEDICAL EQUIPMENT ARE INFLATED FAR ABOVE THEIR ACTUAL COST BY BILLING FOR COMPONENT PARTS. SOME SUPPLIERS APPEAR TO BE UNBUNDLING DME EQUIPMENT AND BILLING ONE CARRIER FOR AN ITEM AND THEN BILLING ANOTHER CARRIER FOR COMPONENTS OF THAT SAME ITEM. THIS ADDS THE FRAUD OF DUPLICATE PAYMENTS TO THE PRACTICE OF UNBUNDLING.

OSTOMY POUCHES CAN BEST ILLUSTRATE THIS POINT. WE ESTIMATE THAT OSTOMY POUCHES PURCHASED FROM A DME SUPPLIER COST ABOUT \$4.00. AMONG OTHER THINGS, THESE POUCHES CONTAIN A BAG, A SKIN BARRIER, AND ADHESIVE. HOWEVER, BY UNBUNDLING OSTOMY EQUIPMENT AND FILING A CLAIM FOR EACH INDIVIDUAL ITEM, THE TOTAL COST WOULD

BE ABOUT \$10.50 OR HIGHER – MORE THAN DOUBLING THE REIMBURSEMENT RATE. THIS TECHNIQUE OVERINFLATES CHARGES AND RESULTS IN INAPPROPRIATE PROFIT MARGINS.

- O WE HAVE A CASE INVOLVING A DME SUPPLIER IN TEXAS THAT ALLEGEDLY UNBUNDLED THE COMPONENT PARTS OF OSTOMY SUPPLIES IN ORDER TO INFLATE THE AMOUNT BILLED TO MEDICARE. THIS SUPPLIER APPROACHED NUMEROUS SMALL OSTOMY SUPPLY COMPANIES WITH AN OFFER TO BUY UP THEIR ACCOUNTS RECEIVABLE. THE COMPANIES WOULD GET THEIR CUSTOMERS TO SIGN A CMNs ALLOWING ANOTHER COMPANY TO BILL MEDICARE AT THE TIME OF THE SALE. THEY WOULD THEN SEND THE INVOICE FROM THE SALE TO THE SUPPLIER, WHO WOULD REIMBURSE THEM FOR THE FACE AMOUNT OF THE INVOICE, AND BILL MEDICARE.

SIMILAR INVESTIGATIONS ARE UNDERWAY IN OTHER STATES.

5. SIGNATURE ON FILE

UNDER HCFA GUIDELINES, CARRIERS PAY CLAIMS SUBMITTED BY DME SUPPLIERS WHICH INDICATE THAT THE SUPPLIER HAS BEEN AUTHORIZED BY THE BENEFICIARIES TO BILL MEDICARE. THIS AUTHORIZATION, OR SIGNATURE ON FILE, WAS DESIGNED TO LIMIT THE ADMINISTRATIVE BURDEN IMPOSED ON PHYSICIANS AND SUPPLIERS BY DISPENSING WITH THE REQUIREMENT THAT THE PROVIDER OBTAIN A BENEFICIARY SIGNATURE ON EACH NEW CLAIM. THIS AUTHORIZATION ALLOWS THE SUPPLIER TO ACCEPT ASSIGNED PAYMENTS FROM MEDICARE.

A SIGNED REQUEST FOR PAYMENT RETAINED IN THE DME SUPPLIER'S FILE MAY BE EFFECTIVE INDEFINITELY. HOWEVER, WITH RESPECT TO ASSIGNED CLAIMS FOR DME RENTAL OR PURCHASE, A NEW CMN IS REQUIRED IF OTHER EQUIPMENT IS RENTED OR PURCHASED. HOWEVER, OUR INVESTIGATIONS HAVE REVEALED THAT SOME CARRIERS HAVE INAPPROPRIATELY ISSUED INSTRUCTIONS STATING THAT SUPPLIERS ARE PERMITTED TO OBTAIN, AND RETAIN IN A FILE, A SINGLE 'LIFETIME' AUTHORIZATION FROM THE BENEFICIARY. ONCE THIS AUTHORIZATION HAS BEEN OBTAINED, DME SUPPLIERS FREQUENTLY SUBMIT CLAIMS FOR 'FREE' ITEMS OR SERVICES WHICH ARE NOT INCLUDED UNDER THE ORIGINAL AUTHORIZATION.

HCFA MUST ENSURE THAT CARRIERS ARE ADEQUATELY REVIEWING CLAIMS TO DETERMINE WHETHER A PHYSICIAN HAS APPROVED THE MEDICAL NECESSITY FOR AN ITEM OR SERVICE, AND THAT DME SUPPLIERS ARE INFORMED OF THE REQUIREMENTS CONCERNING SIGNATURE ON FILE. OTHERWISE, IT IS DIFFICULT FOR US TO PROVE THE SUPPLIERS HAD THE CRIMINAL INTENT TO DEFRAUD.

6. MEDICARE CARRIER PROVIDER NUMBERS

MEDICARE CARRIERS ASSIGN PROVIDER NUMBERS TO PROVIDERS OF PART B SERVICES WHO FURNISH EQUIPMENT TO BENEFICIARIES. THE NUMBERS ARE USED FOR PROCESSING CLAIMS AND ESTABLISHING PRICING AND UTILIZATION PROFILES. UNFORTUNATELY, ANYONE CAN GET A PROVIDER NUMBER, OR PROVIDERS CAN GET MORE THAN ONE NUMBER IF THEY WISH. THIS IS BECAUSE EACH CARRIER HAS ESTABLISHED THEIR OWN SYSTEM FOR ASSIGNING PROVIDER NUMBERS. IN SOME AREAS IT'S NOT EVEN NECESSARY TO FILL OUT AN APPLICATION – ONCE A CLAIM IS SUBMITTED, A PROVIDER NUMBER IS ASSIGNED. THIS PERMITS DUPLICATE BILLINGS FOR THE SAME SERVICE OR PRODUCT UNDER DIFFERENT NUMBERS.

IN ADDITION, THERE IS NO REQUIREMENT IN APPLYING FOR A PROVIDER NUMBER THAT THE PROVIDER STATE WHETHER OR NOT THEY HAVE A PRIOR CONVICTION OR HAVE BEEN SANCTIONED. A COMPANY COULD BE CONVICTED OF FRAUD – OR SANCTIONED IN SOME WAY. BUT THERE IS NOTHING TO PREVENT THE SAME OWNERS FROM GETTING ANOTHER PROVIDER NUMBER, STARTING UP ANOTHER COMPANY – AND DOING BUSINESS WITH MEDICARE AGAIN.

- O WE HAD A CASE INVOLVING SEVERAL TEXAS DME COMPANIES AND THEIR CO-OWNERS – LINDA BAXTER AND TOM EWTON. IN THIS CASE, EACH APPLIED FOR TWO PROVIDER NUMBERS. THE COMPANIES – WHICH WERE ESSENTIALLY PAPER OPERATIONS – BILLED MEDICARE FOR TREATING THE SAME PATIENTS AND PROVIDING THE SAME EQUIPMENT. WE OBTAINED CONVICTIONS AGAINST THEM ON CHARGES OF MEDICARE FRAUD. RECENTLY, LINDA BAXTER WAS SENTENCED TO 4 YEARS PROBATION AND 4 MONTHS HOME DETENTION, AND ORDERED TO REPAY \$16,600 SHE OBTAINED BY FILING FALSE MEDICARE CLAIMS. TOM EWTON WAS ALSO SENTENCED TO 5 YEARS PROBATION AND 1 MONTH HOME DETENTION, AND ORDERED TO MAKE RESTITUTION OF \$11,900.

WE HAVE BEEN WORKING ON PROVIDER NUMBER PROBLEMS FOR SEVERAL YEARS. OUR INVESTIGATIONS HAVE REVEALED PROBLEMS WITH CARRIER PROCEDURES AND ABUSE OF PROVIDER NUMBERS. SOME YEARS AGO, WE ISSUED A MANAGEMENT IMPLICATION REPORT TO HCFA EXPRESSING OUR CONCERN WITH THE APPARENT LACK OF UNIFORM REQUIREMENTS IN

THE ASSIGNMENT OF PROVIDER NUMBERS. WE HAVE RECOMMENDED STANDARDIZED, COMPREHENSIVE APPLICATION FORMS FOR ISSUANCE OF PROVIDER NUMBERS BUT HCFA HAS TOLD US THAT WOULD BE ADMINISTRATIVELY BURDENSOME ON THE CARRIERS. WE ARE UNAWARE OF ANY SUBSTANTIVE CHANGES RESULTING FROM ANY HCFA STUDY.

WE HAVE BEEN CONDUCTING NATIONWIDE REVIEWS OF PROVIDER NUMBER ISSUES. WITH YOUR PERMISSION, WE WOULD LIKE TO SUBMIT A COPY OF OUR REPORT ENTITLED "CARRIER MAINTENANCE OF MEDICARE PROVIDER NUMBERS" WHICH WAS JUST RELEASED. WE FOUND THAT HCFA'S DIRECTION TO CARRIERS IS INADEQUATE AND THAT WEAKNESSES EXIST IN CARRIER CONTROLS TO MAINTAIN PROVIDER NUMBERS. AT PBS ALONE, WE IDENTIFIED 1,590 ACTIVE CARRIER PROVIDER NUMBERS BELONGING TO PROVIDERS WHO HAD LOST THE LEGAL AUTHORITY TO PRACTICE. WE FOUND OVER \$78,000 IN ALLOWED CHARGES TO THE PROVIDER NUMBERS SAMPLED. THESE RESULTS REINFORCE PAST OIG FINDINGS. OUR REVIEW OF FLORIDA PHYSICIANS FROM 1980 - 1985 SHOWED CARRIERS ALLOWED CHARGES IN EXCESS OF \$15 MILLION FOR SERVICES RENDERED BY 439 PROVIDERS AFTER THEY LOST LEGAL AUTHORITY TO PRACTICE.

IN OUR REPORT, WE RECOMMEND THAT HCFA REQUIRE CARRIERS TO UPDATE PROVIDER RECORDS PERIODICALLY. THIS WOULD INCLUDE THE REQUIREMENT THAT CARRIERS ESTABLISH CONTROLS TO ENSURE THAT PROVIDERS NOT LEGALLY AUTHORIZED TO PRACTICE ARE IDENTIFIED AND THEIR PROVIDER NUMBERS DEACTIVATED. ADDITIONALLY, HCFA SHOULD REQUIRE CARRIERS TO DEACTIVATE PROVIDER NUMBERS WITHOUT CURRENT BILLING HISTORIES. FINALLY, MAINTENANCE EFFORTS SHOULD BE EVALUATED AS PART OF HCFA'S REGULAR CONTRACTOR PERFORMANCE EVALUATION PROGRAM.

WE ARE ALSO DRAFTING ONE OTHER REPORT THAT EXAMINES THE PROCEDURES WHEREBY MEDICARE CARRIERS ASSIGN A PROVIDER NUMBER UNDER MEDICARE PART B, AND THE VULNERABILITIES IN THESE PROCEDURES. WE WILL DETERMINE WHAT DOCUMENTATION AND PRE-AUTHORIZATION IS NEEDED TO PROTECT THE FINANCIAL INTEGRITY OF THE MEDICARE PROGRAM. WE WILL RELEASE THIS REPORT LATER THIS YEAR.

DEFINITION AND PRICE OF DME

WE HAVE CONCERNS ABOUT THE LACK OF STANDARDIZED DEFINITIONS OF DME. WHILE DEFINITIONS EXIST - IN THE FORM OF CODES - FOR PHYSICIAN SERVICES, HCFA HAS NOT DEVELOPED STANDARDIZED DEFINITIONS OF MEDICAL EQUIPMENT OR PRICING GUIDELINES FOR WHAT THIS EQUIPMENT SHOULD COST.

HCFA SHOULD IMMEDIATELY ESTABLISH STANDARDIZED DEFINITIONS THAT INCLUDE QUALITY STANDARDS - THERE ARE CURRENTLY FEW SUCH STANDARDS IN THIS AREA OF THE MEDICARE PART B PROGRAM. THIS HAS HAD A SIGNIFICANT IMPACT ON THE EXTENT OF THE FRAUD WE HAVE SEEN. FOR EXAMPLE, HCFA HAS NO SPECIFICATIONS THAT DEFINE A "MEDICARE APPROVED" DECUBITUS CARE MATTRESS. THIS HAS ALLOWED UNSCRUPULOUS DME SUPPLIERS TO PROVIDE MEDICARE BENEFICIARIES WITH PRODUCTS THAT HAVE LITTLE OR NO MEDICAL VALUE. THESE STANDARDS WOULD HELP ENSURE THAT THE MEDICARE BENEFICIARY IS RECEIVING USEFUL ITEMS AND THAT THE MEDICARE PROGRAM GETS WHAT IT PAYS FOR.

STANDARDS FOR DME EQUIPMENT IS A START, BUT ADDITIONAL CORRECTIVE ACTION IS REQUIRED. WE BELIEVE A NATIONAL SINGLE PRICING SCHEDULE SHOULD BE ESTABLISHED FOR ALL DME THAT COULD TAKE INTO CONSIDERATION LOCAL MARKET VARIATIONS.

CONCLUSION

OBRA '90 INCLUDED SIGNIFICANT REFORMS IN THE AREA OF DME. THESE CHANGES SHOULD REDUCE MANY ABUSIVE DME PRACTICES AND EXCESSIVE DME COSTS. HOWEVER, IN MANY CASES, REGULATORY AND MONITORING ACTIVITY HAS NOT BEEN FORTHCOMING.

FOR EXAMPLE, THE REQUIREMENT FOR PRIOR APPROVAL FOR POTENTIALLY OVERUSED ITEMS SUCH AS TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS), MOTORIZED SCOOTERS AND OTHER ITEMS FREQUENTLY SUBJECT TO UNNECESSARY UTILIZATION WAS SUPPOSED TO GO INTO EFFECT ON JANUARY 1. THIS REQUIREMENT HAS NOT BEEN PUT INTO EFFECT AND IMPLEMENTATION HAS BEEN SUSPENDED INDEFINITELY. WE ALSO UNDERSTAND THAT THE REQUIREMENT THAT SUPPLIERS CANNOT COMPLETE THE CMN HAS BEEN DELAYED INDEFINITELY. HCFA SHOULD TAKE STEPS TO VIGOROUSLY IMPLEMENT OBRA '90 BY ISSUING THE ADDITIONAL REQUIRED REGULATIONS IN THE AREA OF DME.

INCREASINGLY, WE ARE FINDING EXPENDITURES FOR DME ITEMS THAT:

- ARE OF LITTLE OR NO USE TO THE BENEFICIARY;
- WERE NOT REQUESTED BY THE BENEFICIARY; OR

O WERE NOT ORDERED BY THE PHYSICIAN.

DME SUPPLIERS WILL CONTINUE TO TAKE ADVANTAGE OF THE CURRENT SYSTEM AS LONG AS HCFA DOES NOT ISSUE ADEQUATE REGULATIONS AND STANDARDS TO THE CARRIERS. IN PARTICULAR, WE HAVE SEEN MANY DME SUPPLIERS MARKETING EQUIPMENT DIRECTLY TO BENEFICIARIES TO INDUCE A DEMAND FOR THEIR SERVICES. THE AMOUNT OF PRESSURE BEING PLACED ON SOME PHYSICIANS EITHER DIRECTLY BY THE DME SUPPLIERS OR INDIRECTLY BY UNKNOWING BENEFICIARIES, FORCES US TO LOOK FOR NEW WAYS TO PREVENT THIS FRAUD.

THIS CONCLUDES MY TESTIMONY. MR. HARTWIG AND I ARE AVAILABLE TO ANSWER YOUR QUESTIONS.

Chairman PICKLE. I appreciate your statement very much. The Chair is going to go next to receive the statement from Michael Baylson.

Do you have a statement to make, Mr. Hartwig, or are you just accompanying?

Mr. HARTWIG. Just accompanying.

Chairman PICKLE. All right. We will hear now from Mr. Michael Baylson, U.S. district attorney, Eastern District of Pennsylvania.

STATEMENT OF MICHAEL M. BAYLSON, U.S. ATTORNEY, EASTERN DISTRICT OF PENNSYLVANIA, U.S. DEPARTMENT OF JUSTICE, ACCOMPANIED BY JAMES G. SHEEHAN, CHIEF OF THE CIVIL DIVISION

Mr. BAYLSON. Thank you, Mr. Chairman. It is a great privilege for me to be here. I am privileged to be accompanied by James Sheehan, who is the Chief of the Civil Division of the U.S. attorney's office.

We very much appreciate all of you coming to the Eastern District of Pennsylvania. It is appropriate because we have had a lot of activity in this area, and it is also a fitting legacy to Senator Heinz, because both Mr. Morey and I were prepared to give testimony before Senator Heinz the day after he was unfortunately killed in a helicopter accident.

Chairman PICKLE. But a great person, a great statesman.

Mr. BAYLSON. Yes, he certainly was. It is very, very fitting that you have taken up the cause that he was championing and the testimony that he had been scheduled to hear.

Health care fraud has long been of intense interest to the U.S. attorney's office in the Eastern District of Pennsylvania. I have been attempting to continue that. We started a fraud initiative in 1988 which was designed to attack fraud in all of its various schemes and guises, particularly Government program fraud which includes, of course, fraud against Medicare.

We have adopted a very strong, active program which we call "Parallel Proceedings," where we attempt to proceed both civilly and criminally and also concerning asset forfeiture wherever the law will allow against the perpetrators of fraud.

Our civil division has shown great leadership. Last year, fiscal 1990, our civil division led the country—led all U.S. attorney's offices—with civil recoveries in excess of \$21 million. It looks like we are going to even exceed that figure this year. I give a lot of credit for that to Mr. Sheehan and the fine attorneys who work in his division.

We believe that we have had an exemplary record of prosecution and enforcement, but there is a lot to go. We had a program where we fined 350 physicians for receiving kick-backs from a diagnostic laboratory a couple of years ago.

We currently have 20 open files against DME suppliers. These include both civil and criminal cases. Since January of this year we have executed six search warrants, and we have cut off six companies from participating in Medicare benefits. We anticipate that there will be prosecutions and civil enforcement actions in a number of these cases.

Perhaps our most notorious case was the one against Mark Mickman that was highlighted in Common Cause magazine. It is discussed in my statement, which I ask it be made a part of the full record.

Chairman PICKLE. That will be done.

Mr. BAYLSON. Thank you, sir.

He operated two companies, Federal Home Care and Home Health Care, and these were the paragons of the telemarketing fraud concept. These were boiler room operations—high profits and shoddy merchandise.

We have a very fine record to show how he was pinned to the legal wall, so to speak. There is an injunction against him, and the companies that we sued went out of business.

The Department of Justice has asked us not to comment on any specific legislative moves that you want to make. I think that is something that they would prefer come out of the Office of Legislative Affairs in Washington.

I do have one request to make, and that is that Congress fund the Major Fraud Act of 1988. That is an act that was passed by Congress in 1988. It gave some additional enforcement powers to civil subpoenas and things of that nature, but it did not provide any additional money for prosecutors to do civil cases; that is, affirmative civil cases in which Mr. Sheehan and his office have shown such great leadership.

We believe that we can work very effectively with HHS. Their Philadelphia office is a model of vigorous enforcement, and we believe that we could bring more cases like the Mickman case if we had additional attorneys to do this kind of affirmative work.

Unfortunately, Philadelphia is a national capital of telemarketing fraud. There is ease of entry. There is high profits to be incurred. If a company is shut down it can reopen under another name and move a few blocks away. It is not difficult at all once somebody knows how to conduct this fraud.

Unless they are put in jail or there is an injunction against them personally they can go ahead and reopen somewhere else. It is a major problem. It is a multimillion dollar problem, and it is growing.

We appreciate the committee's attention. Thank you.

[The prepared statement follows:]

TESTIMONY OF MICHAEL M. BAYLSON
U.S. DEPARTMENT OF JUSTICE

Good morning. I am Michael Baylson, United States Attorney for the Eastern District of Pennsylvania. With me is Jim Sheehan, Chief of the Civil Division of my office.

I appreciate the opportunity to speak to you this morning about the problem of Medicare fraud by durable medical equipment supply firms using direct telephone marketing to senior citizens. Based upon our experience and upon investigations by this office working with the Regional Office of Inspector General, Department of Health and Human Services, and the Federal Bureau of Investigation, we believe that this type of Medicare fraud is a substantial and growing problem within Pennsylvania, which threatens the health and safety of senior citizens, the relationship of trust and confidence between physicians and their patients, and the finances of the Medicare Trust Fund.

As you know, I am obligated by law and by Department of Justice policy to limit my remarks concerning particular persons or firms to matters which are already of public record. I will attempt, in addition, to provide an overview of the categories and types of problems we have identified in this area, without identifying specific firms or individuals.

BACKGROUND

Fraud against the Medicare program has long been a law enforcement priority within the Eastern District of Pennsylvania, and this District has been a national leader in developing new prosecutive techniques to deal with more sophisticated and complex health care frauds.

In 1980, this office organized a Combined Federal Medicare/Medicaid Task Force, together with the Attorney General of the Commonwealth, the Office of Inspector General of the Department of Health and Human Services, and the Federal Bureau of Investigation to investigate, develop, and prosecute major health care fraud cases. That Task Force continues in operation today, and it has been responsible for significant prosecutions against senior hospital officers (Kensington Hospital, Eugenia Hospital, Giuffre Hospital); prominent physicians, including the President of the Cardiology Division of the American Society of Osteopathic Physicians; numerous medical clinics and laboratories; and a variety of other medical providers. In 1988, in the case of MDS, Inc., the Task Force identified and obtained civil penalties from over 350 physicians who received kickbacks from a diagnostic laboratory, the largest kickback case in the history of such prosecutions.

When I became United States Attorney in 1988, I set in motion a Fraud Initiative designed to focus on health care fraud and other procurement fraud. One of my management objectives at that time was to ensure that criminal prosecution did not occur in a vacuum--that every fraud case against the United States should involve, as appropriate, criminal prosecution of the wrongdoers, civil litigation to recover the losses and costs of this conduct, administrative sanctions including exclusion from further government business, and identification of weaknesses in federal programs which permitted these frauds to occur. Although a variety of federal officers have responsibility for these areas, I wanted to ensure that our efforts were coordinated to achieve these objectives. The problem of durable medical equipment fraud, and the support of the Office of Inspector General of HHS, made this area an excellent one to implement this approach.

At the present time, this office has open files involving over 20 durable medical equipment firms representing over \$25 million in sales to Medicare. The growth in both the number of cases referred to this office, and the dollar volumes in the past four years has been exponential. As recently as 1987, we had only two open files for Medicare telemarketing fraud in medical equipment.

EXAMPLES OF DME TELEMARKETING

The complaint in United States v. Mark Mickman, a civil false claims action brought by this office, sets forth an example of the type of operation involved in durable medical equipment sales through telemarketing. Mickman owned and controlled two firms, Federal Home Care and Home Health Care Products, Inc. He started in business in 1988. By November, 1989, he had billed Medicare for over \$8 million for equipment.

Mickman hired women and female high school students to call Medicare beneficiaries. Some beneficiaries had previously responded to an advertisement which appeared in local newspapers offering a "Free Medicare Covered Package Plus A New Special Courtesy Card". The ad does not mention medical equipment.

The telemarketers, most of whom had no prior experience with medical equipment, were given rigidly controlled scripts for calling beneficiaries.

Once telemarketers obtained a patient's name, Social Security number, and a "diagnosis" (for example, arthritis), and the name of the patient's treating physician, they were instructed to check a "so-called bad doctor list" of physicians who refused to approve equipment orders from the firms. If the doctor was not on the list, a second script outlined the conversation with the doctor's office.

Based upon the "diagnosis", another employee would prepare a sales list of equipment which Mickman knew the Medicare carrier would not question for that diagnosis, without any information that the equipment was needed or wanted. A certificate of Medical Necessity (CMN) would be prepared for the doctor's signature, containing the factual representations which would cause the Medicare carrier to pay the claim.

A form cover letter would be sent with the CMN, to the physician suggesting that the patient and the equipment had previously been discussed with the physician's office.

If the physician failed to return the CMN, after several reminders, nothing further was done with the "order". If a CMN was returned, the equipment was delivered by common carrier to the beneficiary, and Medicare would pay.

Another script instructed employees how to deal with complaints from beneficiaries who did not want the equipment. They were told:

- READ SCRIPT -

Physicians who called to complain were told their patients wanted the equipment, and the patients would be charged personally unless the doctor signed. Patients who called would be told their doctors wanted them to have it.

Mickman's business practices are described in greater detail at the cover story of Common Cause Magazine in the January/February 1991 issue.

What I have described here is, in many ways, a classic confidence scheme. It relies upon physicians' confidence in their patients ordering only equipment they really want and need, in patients' confidence in their physicians' judgment about their medical requirements, and in Medicare's confidence that the patient's physician is in the best position to determine whether his patient's condition requires medical equipment. The trust of each in the others is exploited to obtain payment for unneeded equipment.

ACTIONS TO DEAL WITH TELEMARKETING FRAUD

We have received substantial help from a number of people in dealing with this problem, which has made it possible to make some progress. Medicare beneficiaries have submitted over 600 complaints in writing to our office and the Office of Inspector General about abusive telemarketing practices. Over 50 physicians have written to our office or called us to complain about abusive practices of some suppliers. The Pennsylvania Medical Society and

the Pennsylvania Association of Medical Suppliers have, in cooperation with Blue Shield and others, begun an Ask Your Doctor program to encourage Medicare beneficiaries to look to their physicians for advice and assistance on medical equipment, rather than an unknown telephone voice. HCFA Regional Administrator Maurice Hartman has written an article for local medical periodicals advising physicians about the problem of unsolicited CMNs. My office has sent speakers out to medical societies, medical schools, and health care administrator and attorney groups to advise of the problem and ask their help.

Finally, we have brought three cases against telemarketing firms, involving a total of 15 defendants. We expect to bring more such cases shortly. Unfortunately, it is only prosecution of such cases which will deter some operators from continuing these practices.

I would be remiss, however, if I were to tell you that these cases against abusive telemarketers are easy to prosecute. They are not.

The basic techniques of DME telemarketers exploit both the confidence between beneficiaries and their doctors and the reluctance of most people to assume the worst about others or to complain:

- 1) for physicians, the telemarketers pre-complete certificates of medical necessity, including highly detailed information about the patient. For example, the precompleted form will specifically represent that the patient is confined to his bed, or to a floor without a bathroom, or will represent that a patient has been instructed in the use of a TENS unit for pain. A busy general practitioner, who may have over 1000 patients in his practice (many of whom he may see no more than once or twice a year) may be inclined to trust a firm that sends him a certificate with such detailed information (certainly many have in the past).
- 2) for patients, telemarketers reassure them that the equipment is at "no cost to you". Patients are told to keep the equipment, it has already been billed to Medicare; keep it, your doctor wants you to have it; keep it, you may not be able to get it again if you do need it someday. Patients are told that it will be at "no cost to you, regardless of whether Medicare pays for it." Patients who complain are put on hold, or transferred, or told that someone will call back later.

To prevail in a medical equipment telemarketing case we must show a large-scale pattern of improper practices and false certifications by numerous employees of a DME company; and that owners knew or approved of such practices. This proof can involve literally hundreds of witness interviews, assembly of thousands of documents, and substantial time and resources. Many of our witnesses find it difficult to come to the court house and testify, and are intimidated or fearful about their own mistakes--the physicians who signed the false certificates, the beneficiaries who did not refuse unneeded equipment. I am prepared to invest the necessary time to prosecute the best of these cases, given other responsibilities of my office.

CAUSES OF THE PROBLEM IN PHILADELPHIA

Medical equipment is billed and paid for by Medicare in Pennsylvania at a rate 50% higher than the national average, according to HCFA's statistics. We believe that the DME telemarketing activity in and from Philadelphia is responsible for a portion of that disparity.

Based upon our investigations, we believe there are three fundamental reasons why this problem is greater in Philadelphia than in many other places:

1) the tremendous profit potential in many types of DME because of the rates paid by HCFA in this service area. These rates have historically been determined by a percentile of the usual, customary, and reasonable charges for such equipment by suppliers in the area, with some minor limitations. Because several of initial telemarketers were here, and there were essentially no sales to anyone who was not a Medicare beneficiary, they reported usual charges which allowed them a profit of 1000% or ten times the cost of the item. By focussing on specific categories, they were able to provide a substantial percentage of total sales in the service area, and increase the customary charges. For some products, the price paid in Pennsylvania by HCFA is double or triple what is paid in other service areas for precisely the same product.

2) The initial telemarketing efforts occurred here. There were firms telemarketing equipment of beneficiaries from Philadelphia from at least 1984. It is extremely easy to enter the DME business by telemarketing; rent an office, run a classified ad for telemarketers, arrange for credit with suppliers, buy telephone lists or run an ad for a free Medicare package for beneficiaries. Someone who is sophisticated in telemarketing and who is familiar with the equipment business as an employee can walk out with the scripts, billing forms and systems, and the names of suppliers, and open up a competing business. If the new business can hire telemarketers from the old business, so much the better. Businesses stayed here because they could hire experienced people,

and could also call Medicare beneficiaries virtually anywhere in the country, delivering by common carrier. We have received complaints from Delaware, Maryland, Tennessee, Texas, Ohio, Michigan, New Jersey, and New York involving the same firms.

3) It is easy to obtain a provider number here. At present, there is no check on persons who apply for Medicare provider numbers in Pennsylvania, and no extensive questionnaire of the applicant.

This concludes my prepared testimony; I would be happy to respond to any questions, consistent with my obligation to limit discussions of particular cases to what is already public record.

Chairman PICKLE. Thank you, Mr. Baylson.

Now the Chair recognizes Mr. Schulze.

Mr. SCHULZE. Thank you, Mr. Chairman. I thank the panel, and I thank them for their testimony.

I share your concern, and I know that it is very difficult to get anywhere. Last year I successfully offered an amendment to reduce the reimbursement rate on the TENS unit by 50 percent. As it went through the legislative process and ended up in the budget reconciliation bill, but in one of those late night sessions somewhere in the Capitol my amendment was removed, and in its place was put a 15-percent reduction.

When you state the reimbursement rate is something that we should work on, I can assure you we have tried. I have tried, somewhat without success.

I would like also to state that I agree with your statement on Senator Heinz. He was a leader in this area. He and I had both discussed having hearings on the topic, and he had called me and asked me to join him in his hearing that he intended to have in Philadelphia. I had said to him at the time no, you go ahead, and I will work in a different area rather than us duplicating the effort. We certainly want to take time to pay tribute to his efforts in this area.

Mr. Morey, have you talked to HCFA about these outrageous prices? What is their response?

Mr. MOREY. We have had numerous occasions to talk to Health Care Financing Administration on the variance in these prices. We have sent them what we consider the schemes and why they vary and what some reasonable recommendations would be to correct this activity.

The HCFA certainly has that type of information available to them, and they certainly are aware of their responsibility. They have not implemented the majority of our recommendations that we have made to them, but let me just assure you that we have continually tried to work with HCFA with what we have found through our investigations, through our audits and through our program evaluations.

Mr. SCHULZE. Do you think the current pricing system makes sense?

Mr. MOREY. Absolutely not. You would think that a hamburger in Wyoming would cost pretty much the—

Chairman PICKLE. Mr. Morey, would you speak into the microphone.

Mr. MOREY. Yes. You would think that a hamburger in Wyoming would cost about what it would cost in Philadelphia, so I think that the variance in these prices from our carriers, although there would be a little fluctuation in prices, certainly not the huge increases that we see.

Mr. SCHULZE. Can you give us some examples of variations from State to State?

Mr. MOREY. For example, oxygen bags in Tennessee we reimburse at \$2.54. In Pennsylvania the reimbursement is \$4.07. A wheelchair cushion in Tennessee is \$41.93. The same wheelchair cushion in Pennsylvania is \$248. We almost have \$200 difference between the States of Tennessee and Pennsylvania.

It will also swing the other way. Listen to this variance. A hospital bed in Tennessee is \$1,632. The same bed in Pennsylvania is \$1,191. In that case it would be better for you to have the bill paid in Tennessee versus Pennsylvania. There certainly is no correlation. It depends on the product.

Mr. SCHULZE. Mr. Morey, is one of your recommendations the changing of the rule that allows DME companies to bill in high payment States?

Mr. MOREY. Well, the whole billing process certainly is a point of contention. If we take a look at that right now, they kind of key on the point of sale where that sale was originated. If you did it by telephone from the State of Pennsylvania you would get a Pennsylvania price.

We think it should be the point of delivery. Wherever that product is delivered would be that carrier's price that Medicare should pay.

Mr. SCHULZE. The 1990 Budget Reconciliation Act requires national floors and ceilings on DME reimbursement rates. I think you are familiar with this. Do you think that the floor and ceiling legislation will cure the problem of over-priced DME equipment?

Mr. MOREY. I think it offers us a false hope, Congressman. In my opinion, the fee schedule that will be adjusted over the next 3 years is based upon what has historically already occurred. If we have billed outrageous prices in the past, that fee schedule is going to be based on that historical data.

Mr. SCHULZE. Does the floor make any sense to you at all? It does not to me. That is why I asked.

Mr. MOREY. I certainly have my opinion. You would think that in some states where Medicare is getting a break that floor is going to raise. Then we are going to be paying higher for the same price in the future, so it made no sense to me.

Mr. SCHULZE. Mr. Hartwig, did you want to add something?

Mr. HARTWIG. It is not just the pricing issue, but it is the quality issue. I think if you look at the equipment up here the pricing seems outrageous, but certainly it is a quality issue that you are dealing with as well.

We have never found a beneficiary in all our interviews that had a legitimate decubitus care mattress or needed a decubitus care mattress. We do not know what a real decubitus care mattress is or what it should cost.

We certainly know that this type of equipment is over-priced, and it is over-priced because just the quality of it is so outrageous. It is so ill-defined. Focusing just on the pricing of the equipment is one of the areas, but there has to be some quality issues here as well.

Mr. SCHULZE. Mr. Baylson, what do you have to do or what do you have to prove to get a successful telemarketing fraud conviction. Whether we call it telemarketing or boiler room, what do you need to get for the civil or criminal conviction?

Mr. BAYLSON. May I defer to Mr. Sheehan?

Mr. SCHULZE. Sure.

Mr. SHEEHAN. If I may answer that, Congressman, the difficulty you face is that you have to prove an artifice or scheme to defraud. To do that, as we have attempted to do and were successful in

doing in the Federal Home Care case, you need a very good investigator like Ms. Gilmore who will go out and interview literally hundreds of beneficiaries and physicians and former employees of the company.

You have to be able to overcome the supplier's defense. The supplier's defense is I am not a physician. A licensed physician signed the certificate of medical necessity. I do not deliver goods without a signed certificate of medical necessity.

In order to show that they developed a scheme to obtain those certificates by essentially a confidence trick, you have to be able to prepare and produce dozens of witnesses in the courtroom. That is an expensive proposition and a time-consuming proposition.

Mr. SCHULZE. Indeed. What might be your specific recommendations for stopping DME fraud?

Mr. SHEEHAN. One of the issues, it seems to me, is that serious consideration should be given as to whether the telemarketing of this equipment should be allowed at all.

The type of equipment we are talking about is in some ways very similar to prescribing drugs. It is hard to imagine a pharmacist calling up Medicare beneficiaries and saying I have this great new drug for you. If your doctor wants you to have it I will send him a prescription, and he can just sign it and send it back.

What we are doing here I think is allowing the same kind of approach. We would never allow that to be utilized with drugs.

Mr. SCHULZE. How would you utilize that choke point? You heard Dr. Bell say that doctors are already overburdened. We have too much paperwork, and we do not have time to do all these things. It seems to me that is an obvious choke point, or perhaps we should call it an opportunity point.

Mr. SHEEHAN. We have made an effort in our office, and the Inspector General has as well, to go out to physicians and physicians groups and say, think seriously about this. What happened with the doctors in my case was that eight physicians had to come into the courtroom and testify that they signed the false statements and sent them through the mail to Medicare. That is a very difficult admission for a doctor to make.

My experience has been that if the message gets out, and the exposure of the physician for doing that gets out; that is, there is a question of whether a criminal prosecution be brought there, but even on the civil side that doctor is looking at a \$5,000 penalty for causing a submission of a false claim, plus triple the amount of the claim.

What we want the doctors to realize is that it is going to happen. There is no question they are being asked to fill out forms and sign them. They are not even being asked to fill out forms, but being asked to sign their names to it. It seems to me a physician should not be signing an order for equipment for a patient unless he knows that the patient needs it and he has seen the patient within a reasonably recent period of time.

Mr. SCHULZE. We have estimates that Medicare fraud may be as high as \$7 to \$10 billion a year. Everybody knows there is a tremendous squeeze on the delivery of medical services in the United States of America. It seems to me that doctors have got to realize that as this squeeze continues, that money has to come from some-

where. It may come out of their pockets if we cannot cut down on fraud and utilize some of that money.

I thank you. I thank you, Mr. Chairman.

Chairman PICKLE. Before we recognize Mr. Jenkins, this question is for either of you, Mr. Morey or Mr. Baylson. The abuses in this DME area by Allstate have been going on now for some time. The investigation has been ongoing for approximately 1½ or 2 years. It is obviously a case of fraud and abuse. Has any suit been filed against an individual?

Mr. HARTWIG. The owner of Allstate is deceased.

Chairman PICKLE. My question is not just on it. Is anybody with any connection to this company or with the medical profession or with—

Mr. HARTWIG. With durable medical equipment in Pennsylvania?

Chairman PICKLE. Yes.

Mr. HARTWIG. Yes.

Chairman PICKLE. In connection with this Allstate approach, is anybody connected with this particular investigation? Has any suit been brought against them?

Mr. HARTWIG. Against Allstate itself, no. Against providers who operate similar to Allstate, yes.

Chairman PICKLE. In other parts of Pennsylvania?

Mr. HARTWIG. Within the Philadelphia area.

Chairman PICKLE. Have you gotten any convictions on them?

Mr. HARTWIG. We have no criminal convictions, although we do have some individuals who have agreed at a future date to plead guilty.

Chairman PICKLE. They have agreed?

Mr. HARTWIG. They have agreed to plead guilty, and as a matter of fact, they are cooperating in some investigations.

Chairman PICKLE. Is the most that you ever get from anyone is to disbar them from practice? Can you do that?

Mr. HARTWIG. If they are convicted of a Medicare-related offense there is a mandatory 5-year exclusion from the program.

Chairman PICKLE. Have you convicted any physician for abuse?

Mr. HARTWIG. As it relates to durable medical equipment telemarketing?

Chairman PICKLE. Yes.

Mr. HARTWIG. No.

Chairman PICKLE. Has anybody ever been fined?

Mr. MOREY. In the DME scene as a whole, Mr. Chairman, yes. For example, in our legislation over the last 3 or 4 years we have recovered about \$18 million in fines. That came from about 39 durable medical equipment suppliers.

Chairman PICKLE. You recovered that from the DME suppliers of equipment?

Mr. MOREY. Yes, we did. Nationwide over the last 4 years there have been about 61 criminal convictions.

Chairman PICKLE. You recovered \$18,000. It is estimated that this year in Medicare we will pay anywhere up to \$3 billion in the DME area.

Mr. MOREY. I did not say \$18,000. It was \$18 million. It is still a drop in the bucket.

Chairman PICKLE. Even so, that is small.

Mr. MOREY. Yes, it is.

Chairman PICKLE. It seems to me like, and it is true in Florida, and I presume we will find other parts of the country, that no suits are ever brought against anybody. No convictions. Nobody is put in jail. Very seldom are they ever fined.

If this is the case, and I think it is the case, then the question that comes to my mind is why is it hard to get at these kind of operators? Why is something not done about it? To me this seems like obvious fraud. It is greatly over-priced. The public is being fleeced out of it.

Mr. BAYLSON. Mr. Chairman, just let me introduce that. Mr. Sheehan can give you more specifics. We have had successful suits—successful civil suits—against DME suppliers where they have been enjoined and they have been fined. We have pending criminal investigations.

In a sense you are right. We could go out, and we could arrest the salesmen easily. We could get a couple here and a couple there. We are doing long-term criminal investigations designed to get at the top of these organizations. I think we are going to have something to say about that before the end of this fiscal year.

Chairman PICKLE. Mr. Baylson, I sure do not want to argue with you or disagree with you because I do not know what the facts are here, but if you are having civil suits or you are doing something about it, have you done more than one or two cases?

Mr. SHEEHAN. One of the things to realize about the civil suit side of the House is that very often we will find out a fraud. The owner will have an attorney. We will confront the owner and say we believe this is a fraud, and we are prepared to prove it. They will say here are our defenses. We will resolve that case on a dollar basis which is substantially in excess of what we can prove they have obtained. We have done that in several cases.

Chairman PICKLE. You settle that, and that person can go back in business again?

Mr. SHEEHAN. It depends. Depending on what we are able to prove, they are either excluded from the Medicare system or they are allowed to continue to participate. Again, it depends on the evidence that we have to bring.

Chairman PICKLE. If you seek a criminal conviction I assume you have to base it on intent to fraud?

Mr. SHEEHAN. That is correct.

Chairman PICKLE. Is that hard to prove?

Mr. SHEEHAN. As we say, Congressman, that is difficult to prove in these contexts because the suppliers point to the physician as the signer, and the doctor has the same explanation you heard here today; that is, I did not intend to defraud anybody. I had no evil intent on my part. All I did was I got this form, and I signed it because I thought my patient needed it.

Chairman PICKLE. Should we base these kind of charges on negligence or malfeasance or something rather than intent to defraud? That would change the picture would it not?

Mr. SHEEHAN. I think it would.

Mr. BAYLSON. I think what is important to recognize is that the supplier pays \$10 for something, and then he goes and charges \$50.

He can look at some schedule and say well, \$50 is what is allowed. I was just doing what all the regulations say.

What we have to show in the civil suit, we have to show a pattern. As Mr. Sheehan said, we have to bring in 10 or 20 witnesses to show that this is a whole pattern and a scheme to defraud. It is not just that they are making a lot of profit, it is that they are making misrepresentations to people. They are not telling the physicians the whole truth.

This requires a lot of evidence. It is one thing to have people come in and testify in front of a congressional committee that this is the experience they have had, but you have to have similar evidence and a lot of it to bring the case in court.

Chairman PICKLE. Mr. Baylson, one more question. You say you could go after the salesmen or somebody else who played a minor role in this, but you do not do that because you want to go after the big boys. Have you gone after the big boys? Have you convicted any of the big boys?

Mr. BAYLSON. We have had civil suits against the big boys. Mr. Mickman is the best example of that. We have criminal investigations that will result in indictments of the big boys within a few months.

Chairman PICKLE. I would venture a guess, and this is an individual guess, that on a scale of 100 to 1 based on your conviction of these DME fraudulent operators not just here in Pennsylvania but across the United States, I bet you you would rate about 5 or 10 on the scale. I just do not think anything is being done.

They are not big money items. It is very difficult to prove as long as you base it on intent to defraud. The system is loosely operated and not overseen. Prices are recklessly set, and nobody cares. When that happens I assume you people in Justice or Health and Human Services put a rather low priority on this issue.

The Chair recognizes Mr. Jenkins.

Mr. JENKINS. Thank you, Mr. Chairman, and thank you for your testimony.

I think the frustration of dealing with this problem is probably increased because of the tremendous amount of money that is involved, first of all.

There is a lot of equipment that is needed, but I think also that many services and the equipment are made available without any oversight whatsoever. Probably most of the physicians would say a lot of this equipment is not even worth anything, and yet we do not exclude its provision.

I understand the difficulty in trying to prove a criminal case, and I understand the time that is involved in trying to put together a case ready for indictment and trial.

Since you have some opinion in investigations I certainly do not want to ask you any questions about that, but is it your experience generally, Mr. Baylson, that these telemarketers move around? They will operate for awhile under this company name, and suddenly they will crop up somewhere else, the same group of people, same group of salesmen and principals.

Mr. BAYLSON. Yes, sir. I think Mr. Sheehan can give you some examples of that and maybe Mr. Hartwig.

Mr. SHEEHAN. Again, the specific names involve current investigations, but there is clearly a pattern of billing. Some of these suppliers will have five or six billing numbers, five or six companies operating out of the same place. If you shut one down they then go into name No. 2, name No. 3, name No. 4.

All you need to run this business, you need two things. You need a Medicare number, and you need a line of credit with the DME suppliers. Once you have that and you start cranking out your certificates and put people in the boiler room at \$6 an hour you have a business that is going to make some money.

If you are working in that business and your boss gets taken down by the Government you go out and you start the operation yourself on your own.

Mr. JENKINS. Then obviously if you are going to try to move on a criminal prosecution you have to have the testimony of some of the people on the inside to help get the principals, which I know is not easily done.

Could you comment upon this provider number? I am new on this subcommittee so I am not really familiar with this. Should this be made available so easily to anyone?

Mr. SHEEHAN. I think Mr. Hartwig is better prepared to answer.

Mr. HARTWIG. I would say no. There is no reason for a durable medical equipment supplier to have six provider numbers. We executed a search warrant earlier this year on a durable medical equipment supplier in Philadelphia. During the course of that search we identified six numbers that that provider was billing under.

The chairman had mentioned the difficulty in criminal prosecutions. We have a case that we have been working on for about a year and a half. It is another direct marketer of durable medical equipment. We are close to a criminal conviction in that case. As a matter of fact, we are assured of a criminal conviction in that case.

In the course of our recent investigative efforts we have found out that that company's billings dropped off dramatically as we were investigating them. Just recently we found out that they had been given another provider number and are still billing in the state under another number.

Especially if you are looking at these types of operations, if you can get a number easily—there is little control over a provider number—a provider number is your ability to bill the Medicare Program. That is exactly what it is. If you have a provider number you can bill.

It is not uncommon for us to identify these companies and to put them under intense criminal and civil scrutiny only for them to drop off in their billings and almost vanish from the face of the earth and just operate under another billing number.

We had a case of a dentist earlier this year, and with the help of Mr. Sheehan we got an \$18.8 million judgment against this one dentist. This one dentist had six billing numbers, two to himself and four to some other individuals that were unaware that he was using their names to bill.

It just means that if you are out to defraud you are not going to do it under one number. You are going to get six, seven, eight. It makes it very difficult in the investigative stage because if you

identify somebody they shut down and operate somewhere else. When you talk about the difficulty of prosecuting someone it is difficult just to find out where they are.

Mr. JENKINS. The bottom line is that this cannot operate unless a physician is a part of it, even though his participation may be through his own negligence. If he does not sign the slip—Medicare and Blue Cross cannot make payment. Is that correct?

Mr. MOREY. That is correct, Mr. Jenkins. We might just throw out one recommendation to you.

Mr. JENKINS. Yes.

Mr. MOREY. If a physician knows you are sick and that you need medicine he can write you a prescription for the medicine. Why can he not write you a prescription for the DME at the same time? By the way, you also need a wheelchair. By the way, you need this paraffin bath or whatever you are going to need. He can do it at the same time. It will take him two seconds to do it, and you would have it.

We would suggest he even put a timeframe on this. If you go to a doctor within 45 days he would have to have given you this prescription or you would have to go back and revisit him. We do not see that that would burden the medical profession that much if he would write it out at the same time you are in the office.

Mr. JENKINS. I am persuaded that that is probably the correct approach. I am not persuaded that a physician ought to be so busy.

Mr. SHEEHAN. Mr. Jenkins, if I may?

Mr. JENKINS. Yes.

Mr. SHEEHAN. One of the things we have not pointed out here is that well over half the physicians who get these certificates throw them away. They refuse to sign them. The suppliers know this.

The way they deal with this is they keep what are called bad doctor lists. A bad doctor is a doctor who will not sign a CMN sent for his patient unless he knows the stuff is needed. What they do is they target the physicians who will sign the certificates.

Mr. JENKINS. That is a good point to bring up because a lot of the physicians are simply very careful not to become involved in this type of activity even though they are trying to help their patients. I understand why they are doing it. There is no fraudulent scheme in their mind. They are simply trying to help the patient.

Mr. SCHULZE. Can you yield at this point?

Mr. JENKINS. Yes.

Mr. SCHULZE. I would like to ask Mr. Baylson and Mr. Sheehan the same question I asked Dr. Bell. Do you know of any schemes where they have been kick-backs or pay-offs involved with this type of operation?

Mr. SHEEHAN. We have four such schemes under investigation at the present time. They range from renting shelves in a doctor's office for \$600 or \$700 a month to cash in white envelopes to checks for various other alleged services.

Mr. JENKINS. So it is going on?

Mr. BAYLSON. Yes, and to follow up on that, 2 years ago we had a program where we filed civil penalty actions against 350 physicians who were receiving kick-backs from diagnostic laboratories. This effort effectively stopped that practice in this district.

When we come out with these actions against durable medical equipment suppliers which are pending in our office right now, we think it is going to have a tremendous deterrent effect.

I appreciate your committee giving this a lot of attention, but I assure you, Mr. Chairman and the other Congressmen, that we are giving this a lot of attention as well. We are determined to make quality cases, and that takes a little bit of time.

Mr. JENKINS. I certainly understand that and am well aware of that. I want to end my questions by personally commending you for your efforts in looking into this problem. I suspect there are a lot of districts throughout the United States that are not really giving this the attention that it ought to have.

My last question is for Mr. Morey. You indicated you settled a case against a dentist for \$16 million or so? Is that right?

Mr. MOREY. Yes, it is.

Mr. JENKINS. I am just curious. Was that paid by his malpractice insurance?

Mr. MOREY. I do not think he has paid it yet, Congressman.

Mr. BAYLSON. He is not worth \$18 million, if I may answer the question. Mr. Sheehan can tell you what our efforts are.

Mr. SHEEHAN. Before the fact he did not want to be covered. After the fact it would have been nice. He still owes the \$18.8 million. The case is on appeal. We are trying to find all the assets we can.

Mr. JENKINS. I am just wondering why malpractice insurance rates go up. On behalf of the legal profession I felt obligated to ask that question. Thank you very much.

Chairman PICKLE. Mr. Morey, I am interested in your suggestion that we might require the physician to actually write out a prescription for the use of this equipment like a prescription for any kind of medicine.

You are saying then that rather than just signing the CMN, the certificate, that he must write out a prescription for the use of that particular item? Is that what you are saying?

Mr. MOREY. That is what my suggestion would be to you, Mr. Chairman. They write out prescriptions by the thousands. They can write out prescriptions for DME.

There are a lot of suggestions and recommendations in our testimony. I would just like to say that a combination of all of them I think would be successful.

Certainly you need a U.S. attorney like we have here with Mr. Baylson to be interested in these cases. Quite frankly, there are U.S. attorneys around the country that do not handle our cases as promptly as we would like.

We certainly know that from an Health and Human Services standpoint that HCFA has some responsibilities. We think our carriers can service a little bit better than they do to use better screens to pop up with these things.

Mr. Hartwig threw out the comment on these provider numbers. I think it is embarrassing to know how many provider numbers we have out there where we do not keep track of those provider numbers.

There is no effort to purge the old ones. If somebody is deceased you would pull that out. If it has been inactive for 5 years you would pull that off to take that element of the fraud away.

It seems like if there are enough of these recommendations that a combination of all of them might be successful.

Chairman PICKLE. Mr. Morey, we, the Congress, should be embarrassed that it is so easy to get a provider number. I think the next panel will consist of individuals who might comment on that.

We, the Congress, cannot be comfortable about that. While we are being somewhat cynical about the lack of prosecution or conviction in these cases, we also I think must point at ourselves because the very origin of our difficulty is the doctor's certificate. They could not move an inch if they did not have that certificate. Somehow we have to tighten up on that. That is for us to write regulations on in committee.

Congress also cannot go ahead and allow an endless number of provider numbers to be issued to an individual.

It is Congress's responsibility also to say there ought to be some way to set a reasonable price for this equipment if it is to be prescribed. To say we just use the regional average really means very little because the regional average could be extremely high in all our proportions to start with. There is nothing to gain by using the formula that we have today.

If we do not find some ways to stop this type of abuse the Congress is going to do something like Mr. Gekas suggested that we just do away with the DME program. That would not be fair because if an individual needs a wheelchair that ought to be prescribed. Medicare ought to be able to meet that need. It would be almost criminal for us not to do it, but to allow this loose operation to continue is not acceptable.

Even though we did not put in all the money you wanted for civil cases it is something that we must recognize is a problem. That is why we are having these hearings, to try to find out from you first hand what you suggest and how we can go about changing it.

What you said this morning and the previous panel have been very helpful to us. We thank you.

Mr. Schulze, any questions?

Mr. SCHULZE. I just want to thank the panel for their very cogent information.

Chairman PICKLE. Thank you very much. Now the Chair will recognize a panel that consists of the Pennsylvania Association of Medical Suppliers and the Blue Shield of Pennsylvania.

Our first speaker on this panel will be Ron Billingsley, who is president of the Pennsylvania Association of Medical Suppliers. Good afternoon to you, Mr. Billingsley.

Mr. BILLINGSLEY. Good afternoon. Thank you.

Chairman PICKLE. On the same panel we will hear from Judith Krafzig-Kearney, who is vice president of the Medicare operations. Ms. Krafzig-Kearney is being accompanied by Donald Baxter and Toni Rivel, or at least Toni Rivel.

Mr. Billingsley, if you will proceed?

STATEMENT OF RON BILLINGSLEY, PRESIDENT, PENNSYLVANIA
ASSOCIATION OF MEDICAL SUPPLIERS

Mr. BILLINGSLEY. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, I thank you for the opportunity to participate in this hearing.

I am Ron Billingsley, and I am president of the Pennsylvania Association of Medical Suppliers. The association represents 250 member companies and thousands of Pennsylvania home medical equipment professionals.

I would like to offer a perspective of the home medical equipment industry that differs from the abusive telemarketers that you have heard about in earlier testimony. I would like to tell you what being a home medical equipment provider means to myself and the members of the Pennsylvania Association of Medical Suppliers.

We see the premature baby who comes home from the hospital because a home care company has provided an apnea monitor to alert the family if the child stops breathing and the training that allows the parents to confidently respond to the alarm.

We see the 35-year-old man suffering from amyotrophic lateral sclerosis—Lou Gehrig's disease—who can live out his remaining days at home because a home medical equipment professional provides a ventilator and 24-hour-per-day support.

We see the 95-year-old woman who is living with dignity in her own home because of the wheelchair, oxygen, and companionship provided by a home medical equipment company.

I am personally appalled by the abuses presented in today's testimony. I applaud the committee's interest in exposing these abuses.

The business leaders of this industry do not believe that these abuses should be defined as the actions of a few bad apples. The existence of one fraudulent dealer or one abusive activity is intolerable. We want to see these people and these practices stopped today.

I would like to make a few comments about what you would find if you visited the typical medical equipment company. You would see a small, local company with a showroom display of equipment, a warehouse in the back and three or four delivery vans.

You would find that the people working there live in the community with their customers. You would find that they meet all of their customers face to face to make sure that they understand how to use the equipment prescribed by their doctor.

You would find that the customer service employees always confer with the patient's doctor about the appropriateness of the equipment before it is delivered. You would find a respiratory therapist and other health care professionals explaining the equipment and training the customer in how to properly use and maintain it.

You would find a company that is recognized by the doctors and the health professional in the community as a colleague in the home care treatment plan for their patients.

I think that it is important for me to provide the committee with this snapshot of the typical home medical equipment dealer because the people who fit this image are outraged that the type of fraud discussed today occurs.

By our standards the business that operates with a telephone and a mail delivery service cannot be considered a provider of home medical care. The ethical businessmen and businesswomen of this industry have been frustrated that not only must they compete with the abuser, but often have been held accountable for their abusive practices.

I believe we can solve these problems. The time is here for the medical equipment industry, Congress, all concerned government agencies and health care professionals to form an alliance based on trust and joint resolve to end fraud and abuse.

I have submitted written testimony to the committee that outlines five specific actions which will help solve these problems. The proposal requires legislative action, regulatory reform, constructive discussion of ethics in the Medicare Program, intense consumer education and targeted action against the conditions which are particularly conducive to abuse.

The HME industry deserves respect for its role in the health care community. I personally pledge my full support and cooperation to provide any resources I can to end these abuses which have tainted the image of a profession that I am proud to be a member of.

Thank you.

[The prepared statement follows:]

Pennsylvania Association of Medical Suppliers'
Comments Regarding Telemarketing Fraud
and the Home Medical Equipment Benefit

The Pennsylvania Association of Medical Suppliers endorses the House of Representatives Ways and Means Committee's investigation of telemarketing practices and scam operators who act as providers of durable medical equipment. PAMS recognizes that the questionable sales techniques and billing practices of some of these companies have been flagrantly abusive and damaging to the Medicare beneficiary, the Medicare trust fund, and to the legitimate provider of home medical equipment and service.

PAMS believes that these problems have solutions. However, before the process of finding the right solution to the problem can begin, the following steps are necessary;

1. Recognize the conditions that create an environment which is favorable for abuse.
2. Review the prior efforts employed to eliminate abuse.
3. Assess the impact of the the previously attempted measures and attempt to understand why they failed.
4. Propose solutions.
5. Evaluate proposed solutions from all perspectives to increase the probability that the most effective options are adopted.

Within this context, PAMS requests that the Committee consider the following assessment of telemarketing abuse in the Medicare program.

I. Conditions favorable to abuse

1. Inaccurate product description and excessive reimbursement -
The manufacturers of home medical equipment produce a wide range of products of vastly differing quality. Some of these products have minimal medical value but are billed to Medicare using descriptions for legitimate durable medical equipment and supplies. The amount paid by Medicare may be excessive for the product provided by the scam provider but not for the legitimate product.
2. Waiver of Coinsurance - Medicare regulations require that providers attempt to collect the 20% of allowable charges not paid by Medicare. The scam provider routinely offers to waive the coinsurance as an inducement to the beneficiary.
3. Venue shopping - This is a practice by which a scam provider submits bills to a particular Medicare carrier based solely on reimbursement rates or coverage policies. For example the Medicare carrier in Ohio approves coverage for specific

urological and skin care products that the Medicare carrier in Pennsylvania denies. Under these conditions an Ohio based company may provide these products to beneficiaries in Pennsylvania and be paid by Medicare in Ohio. This practice is possible because the regulations about jurisdiction of claims are ambiguous and the coverage policies are not consistently and uniformly interpreted by the carriers.

4. Uninformed consumers- An unfortunate fact is that consumers are duped everyday by fast-talking salesmen. This situation is exacerbated by the complexity of the Medicare program which is confusing and misunderstood by the Medicare beneficiary.
5. Minimal risk for the abuser- This also is an unfortunate fact. The scam provider has been able to operate with little risk of timely prosecution or sanctions.

• II. Efforts made to curb abuse

1. PAMS has actively participated in efforts to eliminate fraud and abuse in the home medical equipment industry. The Association and many individual member companies have consistently assisted both the Medicare carrier's Utilization Review Unit and the Office of the Inspector General in the investigations of questionable Medicare business activities. PAMS, in alliance with the Pennsylvania Medical Society, AARP, and Pennsylvania Blue Shield, developed and distributed a pamphlet titled "Check With Your Doctor First." The purpose of this campaign was to alert Medicare beneficiaries to scams involving Medicare and home medical equipment.
2. The national associations representing the home medical industry have also taken a firm position against fraud and abuse in the Medicare program. Both The National Association of Medical Equipment Suppliers (NAMES) and the Health Industry Distributors Association (HIDA) have offered many industry training programs and seminars on the fraud and abuse issue affecting this industry. NAMES has expanded the PAMS "Check With Your Doctor First" campaign nationally and enhanced the program through the development of "A Shoppers Guide to HME." The Code of Ethics and bylaws of the Association bar membership to anyone convicted of a felony related to the business or excluded from participation in either the Medicare or Medicaid program.
3. The Office of the Inspector General has obtained a number of convictions and is currently investigating program abusers. Inspector General Richard Kusserow and representatives of his office have frequently participated in and contributed to the meetings, seminars, and publications of the home medical equipment industry.
4. Congress and HCFA have passed legislation and revised regulations. In OBRA 1987 Congress passed legislation developed by the HME industry. This legislation, commonly known as the Six-Point Plan, reduced Medicare expenditures by

capping the number of months that Medicare would pay for the rental of most HME, limiting payment for inexpensive or routinely purchased equipment, establishing a fixed payment rate for oxygen products, and reducing payment rates for products identified as abused. In addition to the payment reductions of OBRA 1987, many policy and procedure adjustments were made by HCFA which intensified the documentation and coverage screening for HME. In OBRA 1990 Congress reduced the HME benefit by an estimated \$215 million and prohibited the HME provider from completing or partially completing the Certificate of Medical Necessity.

III. Assessment of impact and reasons for failure

It is an irony that despite the efforts by all of these groups the scam artists appear to be more numerous and more profitable today than they were previously. The question that must be answered is, "Why have the efforts of so many failed to have any impact on the abusers?"

PAMS believes that the effectiveness of each group is compromised because their efforts have been fragmented and unilateral. The inability of the HME industry, the Medicare carrier, HCFA, the OIG, the Congress, and the Medicare beneficiary to address the issue of abuse as a coalition with a common purpose has surely contributed to the minimal impact on abuse.

Despite the attempts by PAMS, NAMES, AARP, and the media, the Medicare beneficiary has not been adequately educated about how to recognize a Medicare rip-off. Consumer education efforts require patience and perseverance for results to be apparent.

The investigations and prosecutions of the Office of the Inspector General have been effective when convictions are obtained. The process, however, is slow, difficult, and does little to deter the fly-by-night operator. The legitimate HME provider is concerned that the OIG has not been more effective. Most HME providers are ethical businessmen and are extremely frustrated that they must not only compete with the abusers but have been repeatedly held accountable for their actions.

The legislative and regulatory actions of Congress and HCFA have made it more difficult for the legitimate HME provider to remain profitable. The scam provider however has been impacted minimally by the budget reductions. This result is not surprising since the scam operator has no business costs for the long term service and care of the Medicare beneficiary while the majority of the legitimate HME provider's business cost are directly related to patient service. The deep HME budget reductions of OBRA 1990 may have the undesired effect of reducing availability of quality products and services from legitimate HME providers.

IV. Proposed solutions

PAMS is committed to cooperating with any efforts which will help eliminate fraud and abuse from the Medicare HME benefit. We believe that solutions are possible if a cooperative effort is made. The time has come for business and the government to form an alliance based on trust and joint resolve.

In this spirit of cooperation PAMS requests that the Committee consider the following proposals to eliminate the abusive practices identified during these hearings.

1. PAMS believes that Congress should enact legislation which will prohibit participation in the Medicare program to HME providers who do not meet certain standards. We believe that the standards should include certification or licensing by a recognized quality assurance organization, thereby restricting or eliminating the scam provider's access to the Medicare program. Recently Congressman Ben Cardin (D-Md) introduced "The Ethics in Home Medical Equipment Act of 1991," HR 2534. This legislation was developed with the National Association of Medical Equipment Suppliers and specifically offers ways to attack telemarketing abuses. I support this legislation and encourage the members of this committee and your colleagues in Congress to co-sponsor and enact HR 2534.
2. PAMS believes that the Health Care Financing Administration should immediately clarify ambiguous regulations, such as those concerning the jurisdiction of claims processing. These vague regulations invite abuse and inhibit prosecution. A process must be implemented by which policy and procedure questions can be quickly and clearly explained in a consistent manner.
3. PAMS recommends the establishment of a Medicare Ethics Advisory Board. The purpose of the group would be primarily to educate providers and beneficiaries about the ethics issues and the Medicare program, similar to the Safe Harbor Regulation prepared, but not yet released by the OIG. We believe that many of the questionable business practices and relationships of Medicare providers are more the result of ignorance than fraudulent intent. A regional group of representatives from the HME industry, the OIG, and HCFA committed to education rather than prosecution may prove to be extremely effective in eliminating unintentional abuses quickly.
4. PAMS suggests that an intensive consumer education campaign be initiated. The campaign goal should be to inform the beneficiary of Medicare about the HME benefit and how to distinguish a reputable HME provider from a scam operator. The success of this approach could be more effective than any other effort because the Medicare beneficiary has the ability to stop the scam provider.
5. PAMS suggests that specific guidelines be developed concerning the waiver of coinsurance. We believe that the current regulations are unclear about the procedures which

should be followed to determine the appropriate circumstances for the justifiable waiver of coinsurance. PAMS recommends that a method for reporting and monitoring the waiver of coinsurance be developed.

V. Evaluation of proposed solutions

It is the work of the Committee to complete the evaluation. PAMS sincerely hopes to have the opportunity to continue working with the Committee on this and other issues concerning Medicare and the HME benefit.

Submitted by:

Ronald J. Billingsley, President
Pennsylvania Association of Medical Suppliers
June 21, 1991

Chairman PICKLE. Thank you very much for that good statement, Mr. Billingsley.

Now we will hear Judith Krafsig-Kearney for your statement. Am I saying the name correctly?

Ms. KRAFSIG-KEARNEY. Yes, sir, you are.

STATEMENT OF JUDITH A. KRAFSIG-KEARNEY, VICE PRESIDENT OF MEDICARE OPERATIONS, PENNSYLVANIA BLUE SHIELD, ACCOMPANIED BY DONALD X. BAXTER AND TONY RIVEL

Ms. KRAFSIG-KEARNEY. Mr. Chairman and members of the subcommittee, I appreciate this opportunity to testify today to discuss processing and oversight activities related to durable medical equipment.

Pennsylvania Blue Shield serves as the Medicare part B carrier under contract with the Health Care Financing Administration for Pennsylvania, New Jersey, Delaware and the District of Columbia metropolitan area. During fiscal year 1990, Pennsylvania Blue Shield processed over 51.6 million claims on behalf of 3.2 million beneficiaries.

My comments will focus specifically on the DME benefit. Durable medical equipment has been a covered Medicare benefit since 1966. Payout for DME has steadily increased over the years. Growth in payout has resulted in a corresponding growth in abuse by select unscrupulous suppliers.

Recognizing the potential for abuse, as well as the unique nature of this benefit, Pennsylvania Blue Shield created a dedicated DME processing unit in January of 1990. This unit is staffed by 135 individuals who process all DME claims through prepayment finalization.

Personnel within the unit are specially trained and utilize an extensive set of guidelines to ensure that only medically necessary and appropriate items are reimbursed.

We believe that most DME suppliers are reputable business people who provide needed supplies and equipment to the elderly. We have, however, encountered situations related to the billing practices and marketing techniques of a select few that have required special attention and scrutiny.

The DME suppliers who abuse the benefit are known to us and are subject to this special scrutiny. Specifically, we have referred 43 problem suppliers via efforts by our Medicare utilization review department to the Office of Inspector General during the past 2 years. In addition, we currently subject 18 suppliers in Pennsylvania and Delaware to intense prepayment review and scrutiny.

It is interesting to note that approximately 30 percent of the denials under the prepayment project involved situations wherein the doctor did not prescribe the equipment.

It is alleged upon discussion with the physician that the supplier altered or added equipment to the certificate of medical necessity or that the physician signed the CMN only to protect the physician/patient relationship—at risk because the supplier has convinced the patient that he medically needs the equipment—or because the supplier harasses the physician into signing the CMN.

These programs present a focused review approach to the problem of DME abuse. Suppliers who abuse the program are identified and screened on a prepayment and postpayment basis as necessary.

Pennsylvania Blue Shield has also implemented or is planning to implement several other programs to supplement and enhance DME oversight activities. The Medical Equipment Preapproval Program, or MEPP, is a legislative project based upon a OBRA 1990 provision which involves medical equipment dealers located in the State of Delaware and the five-county Philadelphia area.

Preapproval must be obtained through physician contact with the MEPP unit staffed with trained nurse analysts. The MEPP program returns the management of beneficiaries' medical needs to the physician versus the supplier. It also eliminates the need for a CMN, thus reducing the potential for altered information.

In an effort to curtail abusive or fraudulent billing practices on an immediate basis, an extensive supplier application and identification process has been established. A 6-month prepayment screen is established for all new suppliers suspected of abuse to ensure that their billing practices can be curtailed immediately.

At the present time, there is no statutory regulation that prohibits a Medicare part B carrier from issuing a provider number. This procedure was developed in response to this deficiency.

A monthly report is being developed which will identify those DME providers potentially billing suspect claims. This prepayment approach will substantially supplement current postpayment activities. Case information will be packaged and forwarded to Medical Utilization Review for further investigation.

Pennsylvania Blue Shield is also in the process of developing parameters for those supplies that have been identified as frequently billed services. We will be publishing a 30-day notification to the supplier community of the change to the medical necessity criteria.

DME abuse is not limited to Pennsylvania; it is a national problem. Ultimate solutions must include provisions within the Medicare law that provide statutory guidelines to assist carriers in dealing with abusive suppliers.

For example, current supplier enrollment procedures are not regulated in any manner. Also, strengthened CMN guidelines with attendant penalties for falsification or completion by the supplier would be beneficial.

The programs defined within this document represent significant effort on the part of Pennsylvania Blue Shield to curb DME fraud and abuse. The fact that abusive situations exist clearly indicates the need for oversight activities.

Unfortunately, the lack of predictable and increased administrative funds severely curtails carrier ability to expand extended review of medically unnecessary services, DME or otherwise.

Current contractor budgets limiting the scope of work for medical review serve as a disincentive to carriers who would like to more aggressively pursue such activities but cannot due to budgetary constraints.

Last, more consistent and effective standardized policy and/or program exclusions related to DME must be promulgated. At the present time a DME supplier can shop for the carrier who reim-

burses the greatest amount and who applies the least amount of medical policy.

As long as there exists a lack of definitive legislative program guidelines, these DME nomads will continue to search for the greatest return.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF JUDITH A. KRAFSIG-KEARNEY
PENNSYLVANIA BLUE SHIELD**

Mr. Chairman and members of the subcommittee, I am Judith Krafzig-Kearney, Vice President of Medicare Operations for Pennsylvania Blue Shield. I appreciate this opportunity to testify today to discuss processing and oversight activities related to durable medical equipment (DME).

Pennsylvania Blue Shield serves as the Medicare Part B carrier under contract with the Health Care Financing Administration (HCFA) for Pennsylvania, New Jersey and Delaware as well as the District of Columbia Metropolitan Area. During fiscal year 1990, Pennsylvania Blue Shield processed over 51.6 million claims. We are responsible for the prompt and accurate processing of all claims; responding to calls and letters from beneficiaries, physicians, and other Part B providers; and protecting the fiscal integrity of the Part B trust fund. Fiscal integrity is ensured through review of claims for medical necessity; application of secondary payer guidelines; and performing prepayment and postpayment oversight activities.

My comments will focus specifically on the DME benefit. Durable Medical Equipment has been a covered Medicare benefit since 1966. Payout for DME has steadily increased over the years. Growth in payout has resulted in a corresponding growth in abuse by select unscrupulous suppliers.

Recognizing the potential for abuse as well as the unique nature of this benefit, Pennsylvania Blue Shield created a dedicated DME processing unit in January 1990. This unit is staffed by one hundred and thirty-five individuals who process all DME claims through prepayment finalization. This process involves claim entry and examination to ensure that all initial requirements, including complete and accurate Certificate of Medical Necessity (CMN) information are met; processing of all claim edits; research of missing/incomplete provider and beneficiary data; and application of medical necessity, Medicare secondary payer, and suspect provider guidelines. Personnel within the unit are specially trained and utilize an extensive set of guidelines to ensure that only medically necessary and appropriate items are reimbursed.

We believe that most DME suppliers are reputable business people who provide needed supplies and equipment to the elderly. We have, however, encountered situations related to the billing practices and marketing techniques of a select few that have required special attention and scrutiny.

DME suppliers who abuse the benefit are known to us and are subject to this special scrutiny. Specifically, we have referred 43 problem suppliers via efforts by our Medicare Utilization Review department to the office of Inspector General during the past two years. In addition, we currently subject 18 suppliers in Pennsylvania and Delaware to intense prepayment review/scrutiny through suspension of 50% of their submitted claims and subsequent development to both the physician and beneficiary to verify the information as submitted. It is interesting to note that approximately 30% of the denials under the prepayment project involve situations wherein the doctor did not prescribe the equipment. It is alleged upon discussion with the physician that the supplier altered or added equipment to the Certificate of Medical Necessity (CMN), or that the physician signed the CMN only to protect the physician/patient relationship (at risk because the supplier has convinced the patient that he medically needs the equipment) or because the supplier "harrasses" the physician into signing the CMN. These suppliers were identified through the efforts of the Philadelphia Regional Office (HCFA) and Pennsylvania Blue Shield and involved a review of patterns of complaints, review of billing history and advertising techniques, among other things. This project was initiated on October 23, 1990. Through May, 1991, 6,932 claims from the 18 suppliers have been subjected to intensified development, resulting in denials or reductions in excess of \$455,000.

The aforementioned programs present a "focused" review approach to the problem of DME abuse. Those suppliers abusing the program are identified and screened on a prepayment and postpayment basis as necessary.

I have described our DME processing unit as well as efforts from a postpayment and prepayment perspective relative to our "focus" on DME abusers. Pennsylvania Blue Shield has also implemented or is planning to implement several other programs to supplement/enhance DME oversight activities:

- **Medical Equipment Preapproval Program (MEPP):** This pilot program was instituted March 18, 1991 for some types of medical equipment often prescribed for Medicare beneficiaries (TENS, seat lifts, power operated vehicles). This is a legislative project (based upon an OBRA 1990 provision) which involves medical equipment dealers located in the state of Delaware and the five county Philadelphia area of Bucks, Chester, Delaware, Montgomery and Philadelphia. Preapproval must be obtained through physician contact with the MEPP Unit, staffed with trained nurse analysts. The MEPP program returns the management of beneficiaries' medical needs to the physician versus the supplier. It also eliminates the need for a CMN, thus reducing the potential for altered information.
 - **Supplier Application Procedures:** In an effort to curtail abusive/fraudulent billing practices on an immediate basis, an extensive supplier application/identification process has been established. Upon completion of the questionnaire by the supplier, it is reviewed by Pennsylvania Blue Shield personnel. The supplier questionnaire is reviewed for duplicate request(s), ownership, tax identification, and business practices (ie: association with current/former abusive suppliers). A six-month prepayment screen is established for all new suppliers suspected of abuse to ensure that abusive billing practices can be curtailed immediately. At the present time, there is no statutory regulation that prohibits a Medicare Part B carrier from issuing a provider number. This procedure was developed in response to this deficiency.
 - **Monthly DME Monitoring Report:** A monthly report is being developed which will be programmed to identify those DME providers potentially billing fraudulent or suspect claims. Criteria are being developed so the system can identify conditions of possible abuse. Data from this report will be utilized to establish prepayment screens. This monthly approach (prepayment) will substantially supplement current postpayment activities that occur on a bi-annual and annual basis. Case information will be packaged and forwarded to Medicare Utilization Review for further investigation.
 - **Process for establishing DME fees:** DME procedure codes have been paid according to a fee schedule since 1989. The basis for the fee schedule is actual charge data for claims submitted during the data base period of January 1, 1986 through June 30, 1987. The fees for subsequent years are obtained by multiplying the base period charges by a Consumer Price Index update factor supplied by HCFA.
- The only mechanism available to carriers to change the fee for an item on the fee schedule is through a process known as inherent reasonableness. This involves the use of various price sources, such as catalogues and other third party payors, to establish a fee that is more representative of the current market price.
- **Prepayment review screens for supplies:** Pennsylvania Blue Shield is developing parameters for those supplies that have been identified as frequently billed services. Following extensive analysis through a program that includes consultant review/input, Pennsylvania Blue Shield will be publishing a 30-day notification to the supplier community of the change to the medical necessity criteria. This process will be subject to revision and, potentially, a more focused review approach.

Conclusion

DME abuse is not limited to Pennsylvania; it is a national problem. Ultimate solutions must include provisions within the Medicare law that provide statutory guidelines to assist carriers in dealing with abusive suppliers. For example, current supplier enrollment procedures are not regulated in any manner. Also, strengthened CMN guidelines with attendant penalties for falsification/completion by the supplier would be beneficial.

The programs defined within this document represent significant effort on the part of Pennsylvania Blue Shield to curb DME fraud and abuse. The fact that abusive situations exist clearly indicates the need for oversight activities. Unfortunately, the lack of predictable and increased administrative funds severely curtails carrier ability to expand extended review of medically unnecessary services, DME or otherwise. Current contractor budgets (limiting the scope of work for medical review) serve as a disincentive to carriers who would like to more aggressively pursue such activities, but cannot due to budgetary constraints.

Lastly, more consistent and effective standardized policy and/or program exclusions related to DME must be promulgated. At the present time, a DME supplier can "shop" for the carrier who reimburses the greatest amount and who applies the least amount of medical policy. As long as there exists a lack of definitive legislative program guidelines, these DME "nomads" will continue to search for the greatest return.

Chairman PICKLE. We thank you very much for both of your statements.

The Chair now recognizes Mr. Schulze.

Mr. SCHULZE. Thank you, Mr. Chairman. I would also like to thank this panel and thank you, Mr. Billingsley, for your very forthright statement.

Mr. Billingsley, you recommend establishing standards for getting a DME number. What specific standards would you suggest?

Mr. BILLINGSLEY. Specifically I think that the requirements for participation in the Medicare Program should be established after an assessment of what level of patient care the Government wishes to be provided in home care.

The current reimbursement system that a number of the people testified today spoke of really was not an accurate portrayal. In OBRA 1990 that reimbursement system really did change significantly. Actually, the change began in OBRA 1987.

I think that as you assess standards for participation that reimbursement level has to be tied into the level of service that Congress believes should be provided. There are accrediting agencies that are in existence now, Joint Commission on Accreditation for Home Care being one and CHAP being the other that are recognized in the industry.

This industry has voluntarily subjected itself to the standards of accreditation. I cannot endorse either one of those as the standards, but they are both organizations that emphasize the quality of patient care, as opposed to the retail end of providing a product. Our association believes that the quality of care is what the durable medical equipment industry represents.

Mr. SCHULZE. Has your organization been able to develop standards for eliminating the bad apples from the business? How can you go about it, or how are you attempting to go about it?

Mr. BILLINGSLEY. Unfortunately we are restricted by the law in who we can include and exclude from our association. We do have within our bylaws a clause that encourages members to follow and obey all Federal laws and regulations, and we do have the ability to terminate membership for those people who have disobeyed those laws. I think that is after the fact.

The measures that we have taken to try and assure compliance are routinely sending out any information that we have in terms of the inspector general's investigations and findings of those investigations.

We have developed with the Pennsylvania Blue Shield staff a strong working relationship over the years. As a matter of fact, just this week in the Philadelphia area there was a joint seminar held that deals with the specifics of day to day operations in a program and how to make the program work the right way for both of the groups.

I think that education is the only tool that we have now. I encourage legislative support to shut down the abusive practice, but I also believe that the regulatory stand is a much more efficient way of dealing with it.

Mr. SCHULZE. Have any of your companies been eliminated from your organization?

Mr. BILLINGSLEY. No, there have not been. Fortunately none of our member companies have been investigated or convicted at this point. I hope to continue with that.

Mr. SCHULZE. You heard some of the witnesses today suggest that DME orders should originate with the doctor, such as a prescription. Do you have any comments on that?

Mr. BILLINGSLEY. I sure do. In the legitimate business practice the DME order does originate with the physician. It originates with the physician through the discharge planner or the social worker in the hospital or through his office manager. In the legitimate DME the order is not solicited business from customers as a retailer may.

I can tell you that our industry would not at all oppose legislation or regulation that said that. However, we would like to be involved in what it means because on the regulatory side, the translation, over the last few years we have run into bureaucratic delays.

Now, OBRA 1990 has a provision for CMN completion by the doctor—certificate of medical necessity completion. With all due respect to the inspector general, on an operational side the physician is not going to take the time to do that, and that type of approach to the problem leads to an access problem for beneficiaries.

I can tell you story after story of doctors who have said I am not doing it. I am just not doing it. I think we need to sit down and figure out what is the right way to assure the doctor's involvement. I do believe he is the focal point of the DME order.

Mr. SCHULZE. Ms. Kearney, I understand that carriers do have the authority to lower outrageous DME prices under the inherent reasonableness law. What is involved with the inherent reasonableness review? What do you have to do, or how can that be implemented?

Ms. KRAFSIG-KEARNEY. It is true that we have the inherent reasonableness provision that we may apply to our codes if we feel that there are fees that are unreasonable. I think a common misconception is that by applying inherent reasonableness you ultimately come up with a fee that is lower than that with which you started with. That is not always the case.

Inherent reasonableness is done at the discretion of the carrier, or HCFA can ask or require us to do so. To date Pennsylvania Blue Shield has applied inherent reasonableness to 70 percent of our DME codes. We actually look at several different pricing sources—at catalogs, consultants, and third-party payers. We have also compared ourselves to other carriers in our surrounding service areas.

It involves coming up with a fee that is reasonable and going out with notice to the supplier community and advising that this is what the fee is going to be. We have to take all those comments into consideration, give another 30 days' notice, and then we are able to implement the new fee.

Mr. SCHULZE. Is it not true, though, that there is no real incentive to you to perform these reviews and lower DME prices?

Ms. KRAFSIG-KEARNEY. That is somewhat a true statement, although we remain concerned and cognizant of DME abuse. We are appalled by what we have heard here today in terms of what is going on. However, it is our job as a carrier to ensure that we safe-

guard our program dollars. That is why we have done some extensive work with inherent reasonableness.

We are also currently applying inherent reasonableness to supply codes. I believe the process is perhaps something that leaves much to be desired, but it is the only option right now that is open to us.

Mr. SCHULZE. Your targeting program for intensified claims review, has that been successful in your opinion?

Ms. KRAFSIG-KEARNEY. We have 18 suppliers on review. We believe it has been successful in that we have been able to take some suppliers who perhaps we have routed to the Office of Inspector General and nothing has been done yet.

What we are doing is sampling 50 percent of their claims, calling the physician and the beneficiary, and we are finding out in many cases that the certificate of medical necessity is being altered.

We heard testimony today from someone who said that a physician did not sign a particular CMN. It is entirely possible that the physician signed the CMN and the supplier actually added to that CMN. That occurs in about 30 percent of the denials we make.

In 10 percent of the cases the beneficiary is not using the equipment. Much like you heard earlier, the beneficiary is out playing golf. The equipment is in a box in the closet, and they claimed they never did need the equipment to begin with.

Chairman PICKLE. Thank you. Mr. Jenkins and Ms. Kearney, will you speak into the microphone, or whoever is being addressed.

Mr. Jenkins.

Mr. JENKINS. I want to thank the panel for their testimony, and I will read all of the recommendations made by each of you.

Let me ask Mr. Billingsley, among your recommendations, I did not see what position the association takes on telemarketing. Maybe I have not read them in detail, but are you opposed to that?

Mr. BILLINGSLEY. One of the earlier witnesses today talked about legal telemarketing being an accepted practice in the retail industry in America. I have to offer my respect for that end of the law.

I do not believe that telemarketing has any place in the Medicare Program. I think that the Medicare Program was designed to provide a benefit for medically needy people. That determination of medical need is between the patient and the doctor.

On the other hand, I believe it was Mr. Levin this morning who indicated that there are a large number of people who need services who do not know what those services are.

I cannot speak for the entire association, because my board of directors would have to approve an endorsement. On a personal level, I do not believe that telemarketing of Medicare beneficiaries is appropriate.

Mr. JENKINS. I see the disparity in prices from one State to another. Do you see any real advantage in or justification for having such disparities?

Mr. BILLINGSLEY. No justification. Advantages are obvious financially if you are in a State with high reimbursement.

Mr. JENKINS. So you would be for a national rate?

Mr. BILLINGSLEY. Well, OBRA 1990 goes toward that. I believe you talked about the floor and the reason for the floor. Mr. Schulze, maybe you brought that up. There is a reason for that

floor. The preliminary impacts of OBRA 1990, which was implemented just in the last couple of weeks, in the business I work for Medicare capped rental equipment was reduced by 49 percent. I cannot live on that. I cannot continue in business. If that was my only business—if Medicare was my only business—I cannot live on that.

The reasons for variation, to be more specific, national pricing is probably a necessary step forward in terms of eliminating forum shopping and procedures like that that lend themselves to abuse.

Mr. JENKINS. I missed part of your statement. The 49 percent reduction, is that across the board?

Mr. BILLINGSLEY. Yes, on capped rental equipment, which is hospital beds and wheelchairs. When Congress enacted OBRA 1990 they did not understand the charge data that was existent in carrier systems.

We are still working with the carrier to try and identify those. I am sure each of you will hear from constituents in your own district in a very short time about how they will be unable to keep their doors open.

Across the Nation those rates for the core products of this industry have been terribly, terribly reduced. That does nothing to impact the telemarketer. That does everything to impact the legitimate businessman.

There is legislation that was currently introduced by Representative Cardin that I would ask the committee to give some attention to. It is entitled the Ethics in Home Medical Equipment Reform Act of 1991. It does address some of the specific issues that are abuse issues, but it also addresses some of the areas that technical corrections are needed in OBRA 1991 to make this a viable industry.

Mr. JENKINS. I am just curious. Based upon your testimony it sounds to me as though the 49 percent, in order to make a reasonable profit, certainly is too much. In order for there to be a recommendation of a 49-percent reduction there must have been some excess in the beginning.

Mr. BILLINGSLEY. I think that there are schools of thought that there are excess profits in this industry. I encourage this type of hearing continuing because maybe a more realistic picture of the true durable medical equipment business will surface. Profit margins in this industry are 5 to 6 percent, bottom line. There are not banking people who are interested in capitalizing it.

Mr. JENKINS. Six percent of what now, sales?

Mr. BILLINGSLEY. The total business.

Mr. JENKINS. On sales?

Mr. BILLINGSLEY. That is correct. One of the areas we do not talk about at this type of hearing is the average days receivable in this industry is 101 days in Pennsylvania. That is an extraordinary amount of time to wait to get paid.

The bad debt percentage in this industry that is the result of unpaid Medicare claims and others runs at 6 to 7 percent. That is extraordinarily high. In America business runs at 1 percent bad debt on average. The number of denials and delays in payment amounts are excessive.

It is not just in the Medicare Program. This is not an attack on Medicare per se. It is carrying into the private insurance industries, and certainly into the Medicaid programs, and the problems that the States are having financially also.

When we look at correcting problems in an industry, I hope we focus on the abuser and the abuses rather than the industry itself.

Mr. JENKINS. Any other comment from any other member of the panel? Thank you, Mr. Chairman.

Chairman PICKLE. Mr. Billingsley, I think you have every reason to be anxious to protect the professionalism of your association and that you ought to feel pride in what the legitimate companies are doing. We can understand that and accept that.

I want to proceed with the question, though, of profit. We have had an example this morning of the so-called fly-by-night operators or telemarketers that are abusing their privilege and conducting fraudulent practices. You state that now the association requires meeting a certain standard. You are the legitimate, good operators. You both are being reimbursed, though, at the same level.

I was shocked to hear this morning that a mattress that would cost \$50 is reimbursed by Medicare for \$726. I have a hard time understanding how then your profit is only 5 or 6 percent when those kind of charges are taking place.

Mr. BILLINGSLEY. The legitimate businessman does not look at these products. I cannot say that in its totality because some of them do have a legitimate medical need.

The business I work for sells the convoluted foam pad that you see in front of it. I, too, was to testify at the Senator Heinz hearing before the tragic accident. Senator Heinz had told me that he was going to use this product, so I did an independent survey of the board of directors for the Pennsylvania Association, 21 people.

I asked them about this product. Not one of them views it or sees it as a Medicare product or ever bills that to Medicare. The cost to the public on a non-Medicare basis ranged from \$15 to \$21.

Now, my comment is if Senator Heinz was told that this cost \$50 somebody was ripping him off and lying to him, because that type of mattress does not cost that. It is not the product that we provide in this industry, and I thank you for pointing that out.

The distinction here is that a legitimate dealer has a vested interest in having quality equipment, as well as quality service provided. When you pay for this item with the same amount as a true decubitus care mattress it does not make sense. Somebody is going to make a lot of money.

Chairman PICKLE. We are led to believe that the rate of reimbursement in Pennsylvania is considerably higher than other areas throughout the United States.

We had a comparison this morning, or at least it was discussed, where a pair of crutches would be \$20 in Virginia, and they are \$76 here in Pennsylvania. Are your Pennsylvania charges that much higher than other parts of the country?

Mr. BILLINGSLEY. I think that on some products they are and on others they are not. Overall I would probably look at the fees nationally and say that Pennsylvania is somewhat higher than the rest of the country.

Chairman PICKLE. We can establish that as a matter of fact.

Mr. BILLINGSLEY. Right.

Chairman PICKLE. We do not have to speculate, and you do not have to defend the practice or the association or your State.

Mr. BILLINGSLEY. Right.

Chairman PICKLE. It is a fact that it is considerably higher. I think we would have to agree that one reason why these telemarketers come into an area is because the reimbursement is so much higher here.

That raises the question then of what should be the charge? We have had discussions that maybe we ought to establish some kind of a national rate. Would you support such a thing?

Mr. BILLINGSLEY. Yes, I would. Yes, I would.

Chairman PICKLE. Would you support the approval by HCFA of a charge that would be reasonable or that would be a national rate? You would?

Mr. BILLINGSLEY. I would ask that HCFA not only include the industry in the discussion of those, but that there be a level of accountability. In the past some of the inherently reasonableness determinations that were made were made, in my view, under a questionable set of circumstances.

Really, Mr. Pickle, it goes back to what I was saying of what are we paying for. Are we paying for a product or a service?

Chairman PICKLE. Have you recommended that change to anybody—

Mr. BILLINGSLEY. It is in my testimony.

Chairman PICKLE [continuing]. Until today?

Mr. BILLINGSLEY. We have worked with our carrier in Pennsylvania. No, I cannot say that I have said we should nationalize pricing.

Chairman PICKLE. I do not know that I can expect you to come into church first and say yes, you are going to recommend these changes, but I think this kind of a hearing probably will focus on charges made on a national basis. I hope we can come up with a better suggestion about it.

Meanwhile, you are taking the high charges. Until we make the changes in the Congress you will continue to do that. I hope that as we examine it we do bring in the different groups so we all have a change to participate in setting the rates. I think that is one aspect we can look into.

I am also concerned about the continued practice of Blue Shield and other providers in issuing these ID numbers, these provider numbers. Why is it so easy? Why do you not protest? Do you approve of it?

Ms. KRAFSIG-KEARNEY. No, we do not approve of the process. We do what we do because there is nothing in our carrier's manual or in the Medicare law that prohibits us from doing it. What we have done is reacted to the fact that there are some suppliers who can set up shop, move from State to State, come into our State, leave our State, come back and get another provider number.

We have developed an extensive provider application process now. We will look to see if there are any cases pending with the OIG. We will look to see if there are any principals that are associated with companies that are under our review, such as the 18 we already have on prepayment review.

We will look for any beneficiary complaints, and we will review any fraud and alert letters that we have to insure that the supplier is pretty much above board. Even if they are not, though, we still issue the supplier number, but then we will put them on prepayment review.

Chairman PICKLE. You have told me about your procedure that you follow. What recommendations have you made to change the procedure or regulation, the provider number regulations?

Ms. KRAFSIG-KEARNEY. We have not made formal recommendations.

Chairman PICKLE. It is a problem. It is a serious problem.

Ms. KRAFSIG-KEARNEY. We have not made any formal appeal to anyone to do that, but we certainly support it.

Chairman PICKLE. Well, I would think that you would be making some recommendations so something can be done and make some specific recommendations that you think would be fair. Otherwise we may just limit it to a very small number.

What is your position with respect to the charges that are made, the rate of reimbursement that Medicare uses? Is it high here in Pennsylvania?

Ms. KRAFSIG-KEARNEY. We do not feel that across the board Pennsylvania is higher than the rest of the country. Quite frankly, we would have to get the fees from every other Medicare carrier, which we do not have.

However, we have found in certain instances we may be high on one item, middle of the road on another and at the bottom of the list on another piece of equipment or supply item.

Chairman PICKLE. I am going to give you some examples of the charges made for this equipment in other States and what you reimburse here in Pennsylvania, if these are accurate figures. I want your response. I have them here. I will get them for you in just a minute.

Here is one example. There is a wide variation among the fee schedules across the country. In testimony before the committee in Congress last year the GAO stated that it had reviewed the fee schedule accounts for 46 different items of DME across the country.

For 95 percent of the items GAO reviewed, it found that the highest fee schedule amount was twice as much as the lowest fee amount. For 40 percent of the items the highest fee amount was six times as much as the lowest.

For example, the fee schedule amount for the purchase of crutches was \$20 in Virginia, \$36 in Washington and \$72 in Baltimore. What is it in Pennsylvania?

Ms. KRAFSIG-KEARNEY. I am sorry. I do not have that information. I am not prepared to speak to each individual item and what we reimburse.

Chairman PICKLE. Is there that kind of discrepancy in the various items?

Ms. KRAFSIG-KEARNEY. I believe there are discrepancies nationwide. I think that has been obvious through the testimony today from the various individuals.

I will say that we operate under the DME fee schedule and have since 1989. Prior to that we operated under a basis of historic charges—prevailing and customary fees—which are based on what

suppliers bill us. When a fee schedule was created that historical data was carried forward.

Chairman PICKLE. I would think that as a representative of Blue Shield and Blue Cross that if you think these charges are extremely high or exorbitant, particularly in your area, you ought to protest them or say something.

Have you ever made a recommendation to HCFA that the charges be changed?

Ms. KRAFSIG-KEARNEY. We have those discussions with the Health Care Financing Administration primarily through our inherent reasonableness efforts. Right now inherent reasonableness is the option open to us.

Chairman PICKLE. Has our agency, HCFA, come to you and asked you what you think about these charges?

Ms. KRAFSIG-KEARNEY. HCFA has come to us and asked us to apply the inherent reasonableness provision to certain codes.

Chairman PICKLE. When you say you have had discussions with them do you mean—

Ms. KRAFSIG-KEARNEY. We have applied our inherent reasonableness to many codes on our own initiative. HCFA has also come to us and said would you look at these codes and apply this factor to these codes also. We have done that.

Chairman PICKLE. Maybe we are getting somewhere. At least there is general agreement that charges are too high. There is general agreement that there ought to maybe be a national standard. There is a general agreement that we certainly ought to have some way to control the provider numbers. I am hopeful that we can get into that.

Mr. Billingsley.

Mr. BILLINGSLEY. Could I please add one comment? The problem with the variation in pricing is so complex that it would take me 1 month to explain reasonable charge methodology to you, but I think an important element has to be considered, and that is the product. What are you billing for?

The crutch in Maryland may well have been a Lofstram crutch, as opposed to a pair of wooden crutches, whereas in another State it was. One of the problems that exist is in the terminology and the coding. There are generic terms that are used for a wide variety or similar or like products. That issue needs to be addressed if you are every going to have an equitable system of reimbursement for product provided.

Chairman PICKLE. Thank you. We started this hearing by I think admitting that the basic problem is the fact that the physician must sign that CMN or else there is no movement. The suggestion has been made this morning that perhaps one way to correct that is to say that the physician must prescribe specifically for the use of one of these DME items. Would you recommend that, too?

Mr. BILLINGSLEY. As I said, I believe that is the way that it usually occurs anyway—a written prescription, a verbal prescription. There is not a lot of difference. That happens routinely.

Chairman PICKLE. You say that is generally done, yet our statistics show that about 40 percent of these things are signed by the physician, and he never knows that he has done it.

Mr. BILLINGSLEY. I cannot comment on that statistic, because that is not my understanding of the business or the industry. The legitimate industry is in contact with the physician prior to the delivery of the product. It is based on a physician's direction.

Chairman PICKLE. Is this so-called MEPP Program working? Is it going to be helpful? Can you tell?

Ms. KRAFSIG-KEARNEY. Right now it has been in existence for about 10 weeks. We are reviewing all seat lift claims, power-operated vehicles and TENS units for a control area, which is the State of Delaware and the five-county Philadelphia area.

We have completed 404 determinations. Of that we are denying approximately 30 percent with the highs being the power-operated vehicles at 68 percent and the lows being the TENS unit at about 26 percent.

We have had no problems yet with the physicians who must contact our office directly. They must contact us and speak to the nurse analyst. We also have situations where the nurse analyst and the physician will discuss the item. When the physician realizes that based on our requirements for diagnoses or whatever else that the patient really does not need the equipment or would not meet the guidelines he actually stops the conversation and does not submit the claim.

We feel that so far it has been successful. We are just finishing up a 3-month report on that project, and we will do another one at the end of 6 months.

Chairman PICKLE. It may be too early, but we are hoping that will be helpful, and we hope we can clear up some of these abuses.

I am interested, Mr. Billingsley. Have any of the companies who have been members of your Pennsylvania Association of Medical Suppliers been involved in any of these schemes and scams?

Mr. BILLINGSLEY. Not to my knowledge. If a report would come in we would immediately contact that person.

On the other hand, we have been involved in the reporting of these operations, too.

Chairman PICKLE. Who do you report this kind of operation to?

Mr. BILLINGSLEY. The inspector general's office and the Utilization Review Department at the carrier level. We will continue to do that. We are more anxious than anyone to end this because it affects our business.

Chairman PICKLE. I can understand that. The Chair wants to ask now, Mr. Schulze, if he or Mr. Jenkins have any questions.

Mr. JENKINS. Mr. Chairman, let me ask one question. The doctor mentioned this form that was an official form that has Medicare and has Pennsylvania Blue Shield and so forth. It says it is an OMB-approved form.

I did not get to question the doctor, but you people signed off on it, did you not? Is this your official form?

Ms. KRAFSIG-KEARNEY. Yes, we developed this certificate of medical necessity. We can accept a prescription or the certificate of medical necessity.

This certificate, though, really serves as a prescription so to speak. It gives all the information that would be required in order for us to process the claim, including the diagnosis, the prognosis and several questions that must be answered depending on the

type of equipment that is being billed. This assists us in being able to process the claim in not having to go back to the doctor one time, two times.

Mr. JENKINS. So this is a form that is widely in use—

Ms. KRAFSIG-KEARNEY. That is correct. To my knowledge it is.

Mr. JENKINS [continuing]. By providers—legitimate or not?

Mr. BILLINGSLEY. That form is actually sent by the carrier to the provider when additional medical information is needed. It is really not unusual that a doctor should see that form.

Mr. JENKINS. Normally a doctor would see this from a multitude of providers, would they not?

Mr. BILLINGSLEY. Right.

Ms. KRAFSIG-KEARNEY. I would also add that we do routinely issue a Medicare report, a bulletin that goes to all of our providers so to speak, where we explain what the form is and what it is all about to help them understand what exactly it is and make sure they look for it and look at it before it is signed.

Mr. JENKINS. One final question, Mr. Billingsley. I understand that on the capped rental items where you have a projected 49-percent decrease for Pennsylvania, that is not true nationwide?

Mr. BILLINGSLEY. That is correct.

Mr. JENKINS. Is it true that you have a projected 49-percent decrease, and that is partly because Pennsylvania prices are so much higher than the rest of the Nation?

Mr. BILLINGSLEY. It may be. It also may be that the data was looked at incorrectly. We are working with the carrier to try and identify that now. It is a complex formula.

Mr. JENKINS. I see some of the figures for the rest of the States are only down 10 or 15 or 20 percent for a lot of the same equipment. I am just curious as to why.

Mr. BILLINGSLEY. That is only part of the formula. There is an automatic 25-percent reduction that kicks in after the third month of rental, which is another section of OBRA 1990. The two things combined are what is causing the significant reduction in revenue.

Mr. JENKINS. Thank you.

Chairman PICKLE. I think this is a very helpful hearing as far as the committee is concerned, and I want to thank this panel for your participation in it. Each time we look into this question we learn a little bit more about it. I think this session of Congress we may make some changes that will help bring about further progress.

I thank you, and I thank you, Mr. Schulze, particularly for inviting us to come to Pennsylvania. We have known how effective you have represented your district for a long time, and now we are glad to come here first hand to talk to your folks.

I say to you people who have come here to listen and who have also reported things to our committee, we appreciate your interest. If the taxpayer is concerned eventually we get concerned and corrections can be made. I am hoping we can do that.

This hearing, as far as I am concerned, has been a very good one. We thank you, Mr. Schulze, and thank you, Mr. Jenkins.

Is there any other statement any of your panelists want to make?

Mr. SCHULZE. Mr. Chairman, I would just like to thank you and the subcommittee for coming to West Chester and to Chester County in southeastern Pennsylvania to look at DME fraud. It is an important issue.

I regret that due to the constraints of travel and time that we could not get to Ms. Rivel and Mr. Baxter, who are the investigators out in the field. We will get their information.

I might just add as a footnote that I have drawn up a five point plan to prevent or stop consumer fraud in DME, and that will be available for all those who would like to have it.

Thank you, Mr. Chairman.

[Mr. Schulze submitted the following:]



DICK SCHULZE

5th District, Pennsylvania

• COMMITTEE ON WAYS AND MEANS



2369 RAYBURN HOB, WASHINGTON, D.C. 20515 • (202) 225-5761

FOR IMMEDIATE RELEASE

CLOSING REMARKS BY
THE HONORABLE DICK SCHULZE ON
PREVENTING FRAUD AND ABUSE OF
MEDICARE DURABLE MEDICAL EQUIPMENT SALES
JUNE 21, 1991

Our investigation of fraud and abuse by Durable Medical Equipment (DME) companies in southeastern Pennsylvania has raised serious questions about the operation of the Medicare program. It is clear to me that basic reforms need to be made in the way the federal government pays for durable medical equipment under Medicare. However, Medicare beneficiaries are, and always will be, the first line of defense against unscrupulous medical companies. Because of their important role, I offer, as a guide to our senior citizens, Dick Schulze's "Five Point Plan" for consumers to stop DME fraud:

- I. **Doctor knows best.** All medical equipment purchases under Medicare require a doctor's approval. If you think you might benefit from a heating pad, back brace, or TENS unit, for example, see your doctor. Only your doctor can say for sure if you really can benefit from it, and it won't cause you harm. Never accept any medical equipment without first checking with your regular doctor.
- II. **Buy local.** If you really need medical equipment and it has been approved by your doctor, chances are you can buy it right in your own community. A reputable local medical equipment dealer probably has been in business for many years and has an able and experienced staff to assist you. Ask your doctor to refer you to a medical equipment company that you can be sure of.
- III. **Keep it to yourself.** Don't give out your medicare number or doctor's name to anyone over the phone, or at any public meetings at senior centers, or apartment complexes, where senior citizens meet. If you are contacted by a DME company or anyone claiming to be from "Medicare" by phone or in person, and they
 - ask for your Medicare number,
 - ask for your doctor's name,
 - offer you equipment at little or no cost,
 something is probably wrong.
- IV. **There is no free lunch.** Don't believe any sales pitch that says medical equipment is "free" or "covered by medicare" at no cost to you. Under the law, beneficiaries are required to pay 20% of the amount Medicare approves for payment to the DME supplier. Companies that waive the 20% co-payment across-the-board are violating the law.
- V. **It pays to complain.** The best defense against fraud is your complaint. If you think something is wrong, get the name and phone number of the company involved and call your doctor, Pennsylvania Blue Shield (1-800-382-1274), or the Inspector General's fraud hotline (1-800-368-5779). You can also write to me: Representative Dick Schulze, 10 South Leopard Rd., Suite 204, Paoli, PA 19301-1342 or call (215) 648-0555.

Chairman PICKLE. Thank you. This will conclude the hearing. The court reporter will go off the record.

[Whereupon, at 1:36 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE AMERICAN ORTHOTIC AND PROSTHETIC ASSOCIATION
(AOPA) BEFORE THE SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS
AND MEANS ON THE SUBJECT OF MEDICARE FRAUD AND ABUSE BY DURABLE
MEDICAL EQUIPMENT SUPPLIERS

June 21, 1991

I. INTRODUCTION

The American Orthotic and Prosthetic Association (AOPA) is the national membership organization representing the approximately 1,200 facilities that provide orthotic and prosthetic (O&P) patient services to the physically challenged throughout the United States. Practitioners employed by AOPA members design and fit orthoses (braces) and prostheses (artificial limbs) that enable these physically challenged individuals to overcome often serious and crippling injuries and return to productive lives. In recent years, O&P has inappropriately been confused with the durable medical equipment (DME) industry, a group of providers who do not comprise an allied health discipline, but merely sell or rent products to support treatment modalities. Congress saw fit to rectify this situation by creating a separate statutory section for orthotics and prosthetics in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). AOPA appreciates this opportunity to comment on the subject of Medicare fraud and abuse by durable medical equipment (DME) suppliers. Because the ongoing investigation regarding alleged abuses within the DME industry has inappropriately implicated O&P, we would like to direct our comments to the impropriety of treating and evaluating O&P and DME in the same manner, particularly in light of the wide differences between these two disciplines that were recognized by Congress in OBRA '90.

II. BACKGROUND ON THE ORTHOTIC AND PROSTHETIC PROFESSION

Orthotic and prosthetic (O&P) services involve the patient care activity of a highly-trained, certified allied health practitioner who evaluates the needs of each individual patient, often in emergency situations, and consults closely with the prescribing physicians to ensure that the patient is fit with the proper orthosis (brace) or prosthesis (artificial limb) for his or her individual needs. The O&P specialist then designs and fits the orthosis or prosthesis for the patient. Once the initial fitting is completed, the orthotist or prosthetist continues to work with the patient, instructing him or her how to properly use the brace or prosthesis and conducting follow-up care throughout the course of the patient's disability or rehabilitation to ensure that the brace or prosthesis continues to fit properly and is properly used by the patient.

The O&P field is a relatively small one, with only about 2,700 certified practitioners available to serve the entire United States. The services of the O&P profession are rehabilitative in nature. Typically, they reduce the length of stay for beneficiaries in costly inpatient setting and help restore mobility and ability to function unaided, making it possible for the O&P patient to return to useful work.

The practice of orthotics and prosthetics (O&P) is unique among allied health disciplines since it calls for a mix of clinical and mechanical/engineering skills. The teaching of those skills necessary to provide specialized O&P clinical care is a painstaking process. It requires each student to be introduced to an extensive interdisciplinary curriculum that includes such varied subjects as anatomy, physiology, kinesiology, and materials property.

III. ORTHOTICS AND PROSTHETICS (O&P) AND DME ARE DIFFERENT AND DISTINCT DISCIPLINES

In the past, confusion over the differences between O&P and DME has caused policymakers in the Congress to inadvertently consider action which dramatically affects the O&P industry due to discrepancies in how "orthotics and prosthetics" is defined. While "orthotics and prosthetics" has been broadly defined by Congress to include a number of items not typically utilized in an O&P practice

Page Two

or items considered to be "DME" by the O&P field, for purposes of our comments, "orthotics" is strictly defined by the O&P field as "orthoses or braces" and "prosthetics" is strictly defined as "artificial limbs."

O&P is radically different from DME in that O&P health care services are individual to the patient and are as much a professional services as a product. The "product" element of the O&P practice (the brace or prosthesis) is only part of the total package of medical care provided by an O&P practitioner. Unlike DME, the brace or prosthesis is typically not a "product" at all in the sense that it cannot be used again by another patient. O&P services require a physician's prescription, and thus utilization cannot be stimulated by direct appeals to the patient through advertising and promotion of a fungible "product."

Further, the O&P medical field is completely different from DME in that O&P has defined body of knowledge, a core of certified practitioners, a well established post baccalaureate educational program in nine major universities and significant professional involvement in the design and administration of treatment for individual patients, often in acute and emergency medical situations. O&P devices are generally custom-fabricated and/or custom fit for each individual patient, unlike DME products, which are reusable or rentable by another individual.

The wide differences between O&P and DME were effectively recognized by Congress in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). Section 4153(a)(1) provides for the creation of a separate statutory section, 42 U.S.C. Section 1395m(h), that pertains only to O&P and moves the O&P reimbursement provisions out of the section of the statute that addresses DME. This statutory separation allows Congress to consider O&P in its own right for purposes of Medicare budget proposals and other Medicare issues.

VI. PERCEIVED ABUSES WITHIN DME INDUSTRY NOT APPLICABLE TO O&P

Both the Administration and Congress are currently in the process of investigating alleged fraudulent practices involving the DME industry within the Medicare program. Among the various marketing and billing techniques and practices utilized by the DME industry that have been a source of concern are the following:

- o "Carrier shopping";
- o "Unbundling" of Medicare billings;
- o High pressure and unscrupulous marketing practices;
- o Use of false certificates of medical necessity; and,
- o "The provider number shell game".

While we concede the possibility of isolated cases of fraud involving a provider of services within the Medicare program, AOPA stands willing to work with Congress, the Health Care Financing Administration (HCFA) and the carriers to weed out the offending providers. However, we firmly believe that the perceived abuses within the DME industry are not applicable to O&P due to the distinct nature of the O&P industry and profession as outlined below.

=====

Page Three

1. "Carrier Shopping"

Success in defrauding the Medicare program by means of the practice of "carrier shopping" can most easily be achieved where a supplier has both the means and sophistication to develop and implement highly technical and intricate schemes aimed at obtaining maximum reimbursement. In addition, there must be a reasonable nexus between a particular supplier and a sufficient numbers of jurisdictions to make the practice profitable.

With the exception a small number of member companies, the majority of O&P facilities can be characterized as small "Mom and Pop" operations primarily confined to one or two jurisdictions. These operations neither have the means or sophistication to orchestrate the elaborate schemes necessary to secure fraudulent Medicare reimbursement rates by means of "carrier shopping." The fact that the typical O&P facility has a presence in a small number of jurisdictions makes it less likely that there would be a significant difference in reimbursement rates between one jurisdiction and another.

It is the position of the O&P field that potential abuses of the Medicare program through "carrier shopping" can be avoided by reducing the number of carriers handling O&P claims. There are currently 58 Part B carriers responsible for making payment to providers of O&P patient services. This carrier structure is not effective and efficient and has contributed to the problems of inconsistent coverage decisions and payment variations. Because the O&P field is extremely small (only 2,700 practitioners nationwide), carriers have little opportunity to develop sufficient expertise and data to render sound coverage and reimbursement decisions. The handling of O&P patient care claims by a large number of carriers has been characterized by inappropriate and inconsistent coverage decisions -- confusing patients, practitioners, and prescribing physicians. In addition, the administrative cost of providing O&P reimbursement is unnecessarily high.

HCFA has already recognized the benefits of a small number of carriers for the entire nation in both the Intermediary and Carrier communities to address concerns about inappropriate and inconsistent coverage decisions and provide efficiency in operations. This method was implemented in the parenteral and enteral nutrition (PEN) and home care areas in the mid-1980's and has proved useful in achieving consistency in coverage decisions, operational efficiency and cost-effectiveness. AOPA believes that the problems associated with "carrier shopping" can be alleviated by reducing the number of carriers authorized to handle the administration for Part B O&P claims.

2. "Unbundling"

The unique nature of O&P prompted the development of the first organized coding system for O&P, now known as the "L-Code" system. This system, which was developed by a coalition comprised of HCFA, AOPA, and Blue Cross and Blue Shield Plans, effectively "unbundles" orthotics and prosthetics to incorporate a product and service component. This system was first tested in 1979-80 in South Carolina and proved very successful. It was later officially incorporated into the Medicare Health Care Common Procedures Codes System (HCPCS), and its use is now mandated for all O&P claims.

Page Four

It is the position of the O&P field that this "unbundled" approach to the Medicare reimbursement of O&P health care services is appropriate because of the unique combination of a personal medical service and skill with a physical object (brace or prosthesis) provided by the O&P practitioner. "L-Code" system has not only served to facilitate efficient and accurate Medicare reimbursement for O&P, it has also had several other important functions. Use of the L-Codes has now been mandated by HCFA for state Medicaid systems and has been adopted by most private health care insurers for all lines of business. In addition, the system permits the exchange of accurate information between HCFA, Medicare Regional Offices, carriers and practitioners.

While the development of the "L-Code" system serves to promote fair and equitable reimbursement through uniform description of O&P devices and componentry, encroachment into the system by other types of providers, such as DME dealers, has resulted in increased costs to Medicare. Under this system, when an O&P practitioner provides a brace to a patient, he or she is reimbursed not only for the brace itself, but for the services relating to the brace, such as the custom-fabricating and fitting of the brace as well as any subsequent visits and repairs. In contrast, when a brace is provided by a DME dealer, the brace is often provided "off the shelf" without any related services. Yet the DME may be reimbursed at the same rate as the O&P practitioner under Medicare. It is the position of AOPA that the "L-Code" system should be restricted to O&P as initially intended.

3. High Pressure and Unscrupulous Marketing Practices

Unlike DME, the very nature of the prosthesis or brace provided by the O&P practitioner, coupled with the attendant health care services, do not lend themselves to high pressure and unscrupulous marketing practices. O&P services require not only a physician's prescription but also a device and services unique to the individual patient. This difference is particularly evident in cases where the patient has suffered a loss of a limb, a circumstance of disease or trauma not choice. Therefore the O&P practitioner cannot create need for a particular device. In addition, due to the fact that O&P devices are generally custom-fabricated and/or custom-fit for each individual patient, these items are not reusable or rentable by another individual, unlike DME products.

4. Use of False Certificates of Medical Necessity

The Health Care Financing Administration (HCFA) has exempted orthotics and prosthetics from the prohibition imposed upon DME against completing and/or partially completing Certificates of Medical Necessity (CMNs) or other documentation submitted to the carrier. Therefore, there would be no need on the part of O&P to falsify CMNs.

5. "The Provider Number Shell Game"

There has been no evidence presented or record of abuse that the national organization is aware of involving an O&P facility. However, any the potential for abuse could be remedied by reducing the number of carriers handling O&P claims.

Page Five

V. CONCLUSION

Orthotics and prosthetics (O&P) is a separate and distinct discipline from durable medical equipment (DME) and has been recognized as such by Congress in OBRA '90. AOPA supports the elimination of fraud and abuse within the Medicare program and stands willing to work with Congress to achieve this goal. However, we urge Congress to treat and evaluate perceived abuses within the Medicare program by members of the DME community separately from O&P, an allied health discipline with no similar record of abuse. In addition, it is the O&P field's foremost request of policymakers that O&P be treated and evaluated separately from DME for purposes of Medicare budget proposals and other related issues.



ALAN H. MAGAZINE
PRESIDENT

July 24, 1991

The Honorable J. J. Pickle
Chairman
Subcommittee on Oversight
Committee on Ways and Means
United States House of Representatives
1105 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Pickle:

The Health Industry Manufacturers Association (HIMA) is pleased to offer the following comments for the record of the Subcommittee's June 21 field hearing on allegations of Medicare fraud and abuse among home medical equipment suppliers. HIMA represents large and small companies that manufacture home care products which provide many individuals with an in-home alternative to institutional care.

HIMA is deeply concerned by the allegations of Medicare fraud and abuse that have surfaced. The actions of a few individual firms reflect poorly on the vast majority of the industry's manufacturers, suppliers, and distributors. The home medical equipment industry serves American citizens who need medical equipment in their home, either to continue to lead productive lives, or if more severely ill, to convalesce at home rather than in a hospital or in a nursing home. Caring for these citizens in their homes is far more desirable for them and can be more economical than hospital or nursing home care. Continued advances in home care, made possible in part by developments in home medical equipment, is critical to the federal government's ability to ensure that Medicare hospital admissions are appropriate and that the length of stays are not extended unnecessarily. This, in turn, will ensure that Medicare beneficiaries receive care in the most appropriate setting.

World Leaders in Health Care Innovation

1030 15TH STREET, N.W., SUITE 1100
WASHINGTON, D.C. 20005-1598
(202) 452-8240
FAX (202) 289-1978



3 8095 00012672 8

The Honorable J. J. Pickle
July 24, 1991
Page 2

HIMA is concerned that the home medical equipment industry has faced a series of payment reductions for equipment and services, largely due to problems caused by the federal deficit. Many firms have suffered substantial losses and have either left the industry entirely or substantially reduced their size. While HIMA recognizes the realities of the budget deficit, we are concerned that companies who manufacture quality products and conduct business within the parameters of the law are being penalized.

Recently, the response of Congress to allegations of fraud is often to cut reimbursement. Unfortunately, that reduction has had little positive effect on fraudulent marketing practices. However, it has had a significant negative effect on the legitimate manufacturers of home care products.

There is no question that fraudulent practices must be dealt with strongly. We believe an important step is to ensure stability in the Medicare marketplace so that legitimate firms continue to serve.

The Health Industry Manufacturers Association applauds the efforts of the Subcommittee to expose fraudulent and other abusive practices in the Medicare program. We look forward to the opportunity to work with the members of the Committee in devising solutions to these problems that will assure a strong home medical equipment industry working for the benefit of the Medicare beneficiaries.

Sincerely,


Alan H. Magazine

AHM:rl



ISBN 0-16-037340-9



90000



9 780160 373404